OVERSIGHT ON THE VETERANS' ADMINISTRATION'S OUTPATIENT HEALTH-CARE SYSTEM

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

NINETY-SEVENTH CONGRESS

SECOND SESSION

ON

OVERSIGHT ON THE VETERANS' ADMINISTRATION'S HEALTH-CARE SYSTEM, AND THE EFFECTS OF VARIOUS LEGISLATIVE MANDATES, ENACTED DURING THE LAST 10 YEARS, ON THE ABILITY OF THE VA TO HANDLE ITS PRESENT AND FUTURE PATIENT WORKLOADS

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OVERSIGHT ON THE VETERANS' ADMINISTRATION'S OUTPATIENT HEALTH-CARE SYSTEM

WEDNESDAY, JUNE 9, 1982

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The committee met, pursuant to notice, at 9:40 a.m., in room 412, Russell Office Building, Hon. Alan K. Simpson (chairman of the committee) presiding.

Present: Chairman Alan K. Simpson (presiding).

OPENING STATEMENT OF HON. ALAN K. SIMPSON, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Chairman SIMPSON. Good morning. I welcome you to this morning's meeting of the Senate Committee on Veterans' Affairs. Our purpose today is to hear testimony on the VA outpatient health-care system, its progress and its problems, and effects of various congressional directives in the last 10 years which have resulted in a great increase in the number of veterans eligible to receive certain outpatient VA health care. I know you know that that is one of my interests.

The committee today will hear from representatives of the VA Central Office, three VA outpatient clinic directors, and The American Legion, VFW, and the AMVETS about present methods used and the ability of the VA health-care system to serve its ever growing and eligible outpatient population.

Perhaps even more importantly, the committee is interested in hearing the witnesses' opinions on the future needs and the ability of the VA to serve the rapidly growing aging veteran population.

It is my feeling that it is time to assess the health-care needs of those veterans who are currently using the outpatient system, the extent to which various VA outpatient clinics, given the current statutory priority system, are able to effectively provide necessary health services and the extent to which they may be able to provide such services during the next decade. It may be necessary for the committee to reevaluate current outpatient eligibility given current fiscal constraints, which in my mind show no signs of lessening as we continue to grapple with this difficult issue of trying to balance the Federal budget.

Another response to this situation might be to reevaluate patient needs and the effectiveness of the current outpatient health-care delivery system. Could more patients be treated by refocussing ex-

isting programs and rethinking the present design of the VA's outpatient system?

Today we shall also examine the VA's method of resource allocation for outpatient care and the extent to which changing geographic and demographic situations may necessitate a different system of allocating funds.

As most here are so well aware, within the next 15 years many millions of World War II and Korean war veterans will be 65 years of age or older. And those veterans will be eligible within the existing resources to receive outpatient health care without regard to income or net worth. Will the VA be able to handle these expanded numbers of eligible veterans whose health-care needs will differ from those of veterans who now receive treatment? What will be the effect on the demand for VA health care of increasing numbers of aging veterans? Those things concern me.

If medicare and medicaid health-care coverage continues to decrease, what will happen in that situation? Should the system be equipped differently to meet the special needs that this largely nonservice-connected aging population will have? And if so, how should that be done?

We are interested in examining all cost-effective alternatives to the present VA outpatient system which may provide better quality or more cost-efficient health care to a greater number of eligible veterans. I am aware of the 3-month outpatient experiment now taking place at the Cheyenne, Wyo. Veterans' Administration Medical Center; not at my direction, mind you. A traveling clinic which is staffed by one physician, one nurse and one medical administrative assistant providing outpatient followup health care to veterans in Torrington who would otherwise have to travel 81 miles to the center to receive treatment.

That experiment appears to be responsive to the concerns of both the veterans and the VA. It would eliminate the need for patients to miss work while they receive followup treatment or to travel great distances if they are ill. And it reduces the cost to the VA for beneficiary travel.

I am also aware of Dr. Gerry Charles' efforts at the San Francisco VA Medical Center. There he has been studying this issue and has come up with an interesting alternative model to current outpatient treatment that appears to provide adequate, maybe better, health care to veterans while decreasing the number of annual outpatient visits. Dr. Charles has implemented a physicians group practice model at his San Francisco Center where four or five general practice doctors give total and comprehensive outpatient care in the primary care health maintenance organization mode to eligible veterans who are permanently assigned to individual doctors within the outpatient practice group.

Doctors are then available by phone around the clock if needed. Consultants were utilized only in specific instances when it is medically necessary for the patient. Whenever possible veterans receive continuity in their health care by having an individual physician, thus enabling them to establish an identity within the VA system.

Initial study results seem to indicate that veterans who use this outpatient model visit the San Francisco Outpatient Clinic two or

three fewer times per year as compared to veterans who use other VA outpatient clinics.

Well, those are just but two examples of the kind of thinking or rethinking that I have in mind. We look forward to hearing your thoughts and concerns about how the VA is presently providing outpatient care and how it will continue to provide such outpatient care in the very near future. We solicit your advice and counsel about what changes and alternatives in the present eligibility system, or what program initiatives may be necessary for Congress to consider in order that the VA may best serve the eligible veterans who need quality health care.

And this committee will be conducting another oversight hearing on the VA health-care system on June 30. That hearing will focus on the ability of the VA to provide extended inpatient health care for aging veteran populations.

So I would ask that each witness summarize his or her statement in 5 minutes in order to allow sufficient time for questions. And, of course, your full statements will be inserted into the hearing record.

Senator Cranston indicates his sincere regret that he could not attend this morning, but he will be reviewing this record carefully, and as ranking member of this committee he will be submitting written questions to today's witnesses.

There is a statement of Senator Strom Thurmond who dropped in for a moment. He's always been highly supportive of veterans and certainly of this Chairman. His friendship and participation is deeply appreciated. And that will be entered into the record without objection.

[The prepared statement of Hon. Strom Thurmond, a U.S. Senator from the State of South Carolina, follows:]

PREPARED STATEMENT OF HON. STROM THURMOND, A U.S. SENATOR FROM THE STATE OF SOUTH CAROLINA

Mr. Chairman, I am pleased to receive testimony concerning the Veterans' Administration's outpatient health-care system.

I want to commend you, Mr. Chairman, for recognizing the important role of outpatient care in providing medical care to our country's veterans. I share the concerns which you have expressed about the ability of the health-care system to meet the increased demand which will be placed upon it in the coming decade as a result of a significantly larger elderly veteran population. Certainly, extensive planning is needed to prepare the medical care system for this increased demand and, to the extent possible, to prepare the system to accommodate geographical shifts in the veteran population.

Mr. Chairman, I want to welcome the distinguished witnesses who will testify today, and I look forward to the testimony on this important matter.

Chairman SIMPSON. So the first group is Dr. D. Earl Brown, Jr., Associate Deputy Chief Medical Director; accompanied by Marjorie R. Quandt, Assistant Chief Medical Director for Administration; Dr. Arthur Lewis, Deputy Associate Chief Medical Director for Professional Services of the VA in Washington, D.C.

So if you will please proceed. Thank you.

TESTIMONY OF DR. D. EARL BROWN, JR., ASSOCIATE DEPUTY CHIEF MEDICAL DIRECTOR, VETERANS' ADMINISTRATION, ACCOMPANIED BY MARJORIE R. QUANDT, ASSISTANT CHIEF MEDICAL DIRECTOR FOR ADMINISTRATION; DR. ARTHUR J. LEWIS, DEPUTY ASSOCIATE CHIEF MEDICAL DIRECTOR FOR PROFESSIONAL SERVICES; RALPH IBSON, DEPUTY ASSISTANT GENERAL COUNSEL; AND JAMES MUST, DEPUTY DIRECTOR OF THE SOUTHEASTERN REGION

Dr. BROWN. Thank you, Mr. Chairman. I would also like to introduce Mr. Ralph Ibson, who is on my left, a Deputy Assistant General Counsel with VA. And I have also brought with me, sitting behind me, Mr. James Must, the Deputy Director of the Southeastern Region.

I will summarize my remarks.

I am pleased to be here today to discuss the Veterans' Administration outpatient health-care program. We believe our ambulatory care program has been and is a successful means of providing appropriate cost-effective care to eligible veterans with minimal disruption of their activities of daily living. Since the eligibility for services and the modes for providing care to veterans is governed in large part by statutory provisions, the growth in the VA outpatient program has been significantly influenced by legislative action.

The passage of Public Law 93-82 in August of 1973 established the non-service-connected veteran's eligibility for outpatient or ambulatory care to obviate the need for hospital admission. As a result of this act, our outpatient program grew dramatically in the 3-year period from 1973 to 1976. This enormous increase in the number of outpatient visits during this period created serious problems in virtually every outpatient facility in the VA system. None of these facilities was originally built for the purpose of providing ambulatory care to any great extent and the rapid changes thrust upon the system were difficult to accommodate within a fixed resource base.

Although these changes produced strain, it should be pointed out that the growth in ambulatory care had a significant impact on reducing the requirements for inpatient health care.

The Congress was aware of this growth in our outpatient program and in 1976 enacted legislation—Public Law 94-581—which required that outpatient care be furnished in accordance with a statutory priority scheme. That act not only established the concept of priorities for care, but also provided the VA with a mechanism to adjust access to service based upon the VA's resources to provide outpatient care.

Since that time, much management attention has been given to assuring the most effective and efficient use of limited outpatient resources. Constant monitoring of this program has produced efficiencies that have allowed us, at least in part, to accommodate additional workloads that have resulted from subsequent legislative initiatives which expanded eligibility for outpatient care to new groups of veterans.

We are not able to meet all the demands for outpatient care that are placed upon the system. Therefore, we have had to exercise the

authority to restrict the eligibility for outpatient services to lower priority groups of veterans.

Mr. Chairman, in your letter to us regarding this hearing you raised the issue of the system's ability to adjust to meet changing and increasing demands for outpatient care in the future, particularly as related to the aging veteran population. With the aging of World War II and Korean conflict veterans, VA and the Congress are presented with major planning and policy questions. Within some 15 years, approximately 9 million of these veterans will be 65 years of age or older. This aging population can be expected to experience a naturally increasing risk of disease as aging proceeds. We would similarly anticipate that they will have an increased need for a wide variety of health-care services, including outpatient care.

We believe that the VA has the capacity to adapt to this phenomenon, and that the key to such adaptation lies in the planning process. We are very much engaged in that very process, but, it would be misleading for us to suggest that the current magnitude of resources will permit us to furnish all the care this older population will need.

In widely publicized remarks, the Administrator has called attention to the dimensions of the aging veteran issue. We believe the committee is taking an important step in addressing itself to this difficult subject. However, since veterans over age 65 are eligible for hospital, nursing home and domiciliary care, a balanced health-care program should allow outpatient care to obviate the need for such hospitalization and to allow necessary pre- and posthospital care to such patients.

Mr. Chairman, in inviting us to testify today you posed a number of issues. Among these, you asked us to discuss the VA's provision of primary, chronic and acute health care in the outpatient settings.

Primary care is the evaluation and management of a patient by a broadly trained physician—usually a specialist in internal medicine or family practice—who may subsequently refer the patient to a medical subspecialist because of needs for more sophisticated expertise.

In many cases the medical needs of a veteran, whether the problem is acute or chronic, may be met most appropriately, and cost effectively, in an outpatient setting, thus obviating the need for more expensive hospitalization. By focusing subspecialty expertise in well-equipped, modern ambulatory care facilities wide variety of consultations and specialty procedures are readily available to both inpatients and outpatients.

It is not uncommon for an outpatient to be seen by many subspecialists during the course of his or her outpatient treatment. Thus, VA ambulatory care services provide a broad spectrum of care for patients with acute and chronic medical problems whether these patients are seen by primary care or highly specialized physicians.

Among the complex challenges we face in administering the VA health-care system is the matter of allocating resources. Our resource allocation method gives consideration to both inpatient and outpatient workloads as well as individual needs of a particular facility. Also, our facility planning is based upon the latest available

demographic studies. Our projections in the past were based in large part on the 1970 census data. However, the 1980 census data, when available, will certainly reflect increased population in our Nations' "Sun Belt" regions, and will undoubtedly require that we alter the distribution of resources.

As you know, the MEDIPP—medical district initiated program planning—which was recently initiated represents an effort to develop a more systematic, refined resource distribution and control system. A central feature of the MEDIPP process is its reliance on demographic analysis at the local facility level to develop future plans. We believe this planning initiative, coupled with other strategic management initiatives currently being developed, will yield an improved basis for equitable allocation of resources.

Consistent with the increase in the percentage of women in today's Armed Forces, the number of women veterans will continue to increase. The largest number of women veterans are World War II veterans closely followed by Vietnam veterans.

Within the next 20 years these veterans may be expected to develop gynecological problems in addition to the normal range of other medical problems. We are currently meeting these needs and our future planning includes consideration of female veteran needs.

Mr. Chairman, you also asked us to comment on the appropriateness of continuing to provide beneficiary travel payments to non-service-connected veterans. It is noteworthy that the VA, unlike any comparable health-care delivery or financing system, is in effect required by law to reimburse many of its health care beneficiaries for the expenses of travel to and from its medical facilities. There is a difference of opinion between the VA and our OMB General Counsel regarding the need for legislation to curtail this program. However, we propose that you introduce legislation to limit the circumstances under which veterans receiving VA care, treatment, or examination for non-service-connected conditions, are authorized to be reimbursed for travel expenses to and from the VA.

In the near future we will forward a draft bill to you that would still permit reimbursement for travel to VA health facilities for veterans receiving care, treatment, or examination in connection with vocational rehabilitation or for a service-connected disability, veterans 50 percent or more service-connected disabled, and VA pension recipients. Also, the draft bill would authorize the Administrator to prescribe regulations to provide for patients' transportation in emergencies and to permit transfer between facilities of a veteran receiving VA hospital or nursing home care.

Although we have no agency position to offer on legislation regarding over-the-counter medicines, we would point out that over-the-counter medications are just as much a part of a patient's treatment as prescription medications. An example is the use of insulin for the treatment of diabetes and aspirin for the treatment of arthritis. We would note that imposing limitations on the use of over-the-counter drugs for certain categories of patients would not necessarily inhibit physicians from prescribing more expensive legend drugs, where available, to take the place of an over-the-counter drug.

Mr. Chairman, that concludes my remarks. My colleagues and I are ready for questions.

Chairman SIMPSON. Thank you very much, Dr. Brown. And let me thank the media representatives who have set up in a very quiet way. I usually gnaw a little on that. They have been very effective and I appreciate that and regret that we had to proceed as scheduled. We have to try to accommodate your request and desire to be present. And I appreciate your handling of that.

So, now Dr. Brown, if I can inquire, I am interested in the extent to which the large growth in the provision of outpatient health-care services since 1973 has affected inpatient utilization. Has this large number of veterans treated as outpatients in any way decreased the number of veterans who would have otherwise received care as inpatients?

Dr. BROWN. Certainly the number of inpatients that have been treated has increased as a result of our outpatient efforts, but operating census has decreased. I am not sure I understood whether you were talking about patients who would ordinarily come in the hospital not coming in the hospital.

Chairman SIMPSON. I think those who would have otherwise received care. How has that impacted upon them, if at all?

Dr. BROWN. I think they have simply been diverted to outpatient care rather than the more expensive hospital care.

[Subsequently, the Veterans' Administration submitted the following information:]

VA MEDICAL CENTER ACTIVITY

Activity	Fiscal year	
	1973	1981
Hospital discharges	812,537	945,245
Average length of stay (days)	42.1	27.3
Outpatient visits	10,858,491	17,929,550

Chairman SIMPSON. What is the uniformity of outpatient care that is available throughout the Nation's VA outpatient clinics? To what extent are these outpatient services in this clinic screening and evaluation processes standardized? How do you handle that?

Dr. BROWN. The screening for eligibility, specifically?

Chairman SIMPSON. Well, are they standard? Do they vary per hospital? What standardization do you have? It seems to me as I review it that each administrator has his own views.

Dr. BROWN. Well, the screening for eligibility is pretty standard in the sense that the patients who report for VA care are used as a basis for determining eligibility for care which, as you know, is founded on statutory entitlement from title 38, United States Code, chapter 17. For certain categories of non-service-connected veterans the question of the availability of VA facilities is also an important consideration. Of course, the local management decision about whether a facility has reached its capacity to care for additional patients is best left a local matter. However, in Public Law 94-581, the Congress decided the order of priority in which outpatient services are to be accorded to veterans Standard instructions in respect

to this congressional requirement have been distributed and are observed by the medical centers. Within these standards, the system provides the discretion necessary for facility managers and staff to organize and deliver high-quality health care to the Nation's veterans.

Chairman SIMPSON. Are the staffing needs that you have more pressing in the inpatient or the outpatient health-care system? And do those needs vary according to geographic region?

Dr. BROWN. I don't think that there is a great variation in the shortage of various specialists comparing outpatient and inpatient areas from one geographic region to another. As you know, we do have some problems in nurse recruiting that are geographically related.

Chairman SIMPSON. In your testimony about MEDIPP, you state that that program coupled with other strategic management initiatives currently being developed will give a more systematic and refined resource distribution and control system. Could you please explain those initiatives a little more specifically? And how long is it going to be before they are developed? Do those plans call for added resources of outpatient clinics in the Sun Belt areas such as southern Florida with a large aged veteran population? What is the situation there?

Dr. BROWN. I would like to ask Ms. Quandt to elaborate on the strategic management process. But first, to address the requirements for the Sun Belt area. Our planning to this date has been largely based upon historical data: What has the workload been and the 1970 census?

As we have access to the data from the 1980 census that will help us plan better as far as the shifting veteran population to the Sun Belt area.

I would like to ask Ms. Quandt to talk about the strategic management.

Chairman SIMPSON. Please.

Ms. QUANDT. There are two aspects of strategic management which would have bearing on the future of resource allocation to our outpatient and inpatient program. One is the concerted effort to develop and to adopt by October 1, 1982, staffing guidelines for DM&S personnel. The goal is that 166,000 employees, or 89 percent of our manpower, will be under staffing standards. We are currently working on nursing, medical administration—which is involved in ambulatory care. Physicians, for example, will not have any guidelines until fiscal year 1983.

The second portion of this project involves a review of how we do assign funds to our various medical centers and clinics. It is a combination formula at the present time based on our experience. The Chief Medical Director will be asked to reach a decision in July as to the use of case mix approach for acute hospital care. Because of our current medical information system we cannot use case mix approach on ambulatory care and have to do that on a capitation or per visit cost. It will take us 1 to 1½ more years to refine the ambulatory care portion.

Between the two it would result in the department head knowing "where the action is" and how funds and staffing need to be diverted to where that activity occurs.

Chairman SIMPSON. Could you comment on the alternatives that I reviewed in my opening comments about Dr. Gerry Charles' practice model and the traveling clinic experiment? And to what extent are those type of experiments encouraged by the VA? And are those type of alternatives included in the resource allocations you speak of and the MEDIPP planning initiatives that you consider?

Dr. BROWN. Various means of handling our caseloads are indeed encouraged throughout the system. And there are quite a number of things that are going. You mentioned Dr. Charles and the Cheyenne traveling clinic. Also, we have a number of traveling clinics from Denver that go to various areas, particularly remote areas, primarily for hospitalization followup as you mentioned.

We do encourage that. And what we are looking for, of course, is a more cost-effective way of handling the patient loads without sacrificing quality. We have not been asked for additional resources to do any of these particular things, because the directors have been able to handle them themselves. If indeed there is a request which is valid, of course we would consider additional funds if it shows a potential costs savings.

Chairman SIMPSON. What would be the result if Congress were to limit non-service-connected veterans' outpatient health-care benefit eligibility to those who may have exhausted all other avenues of receiving health care in the community, or those who meet a minimum income standard?

Ms. QUANDT. I would like to supply the total answer for the record. I think from previous testimony we would have by attrition for those, for example, who have used all possible medicare benefits we would gain 4,000 patients a year. But we will have to provide the rest of the answer for the record.

[Subsequently, the Veterans' Administration furnished the following information:]

The enactment of legislation limiting non-service-connected outpatient health care benefits to those veterans who have exhausted all other avenues of receiving health care in the community or those who meet a minimum income standard would result in restricting the use of VA facilities for the care of certain groups of non-service-connected veterans who by present statute are entitled to receive VA outpatient medical services. These groups would include the following:

Former prisoners of war; World War I veterans; Mexican Border veterans; veterans claiming exposure to agent orange or ionizing radiation; non-service-connected veterans receiving aid and attendance or housebound allowances; veterans requiring services necessary in preparation for or to obviate the need of hospital admission; and veterans requiring outpatient non-service-connected care to complete a period of hospitalization.

Such an action would further result in an unbalanced health delivery system as inpatient care would be provided but necessary outpatient followup would be prohibited leading to increased inpatient costs due to patients remaining hospitalized longer because completion of the episode of care could not be provided on an outpatient basis.

The workload impact and the impact of said action on the private sector cannot be estimated with great reliability at present. The administrative burden placed on the VA would range from minimum by accepting the veteran's statement as to availability of community resources and/or income; to a major burden if verification of the veteran's statements was required.

Chairman SIMPSON. I understand the numbers. I am wondering about the results of that. What would that be?

Mr. IBSON. Sir, would I be correct in understanding at least one facet of the implication of that suggestion to be that veterans would not have eligibility for posthospital care?

Chairman SIMPSON. I'm speaking of non-service-connected veterans' outpatient health care, whatever that full spectrum is. Pre- or posthospital care.

Mr. IBSON. I was just trying to clarify for Dr. Brown my understanding of at least one facet of that question. And that is that non-service-connected veterans to whom we might have furnished hospital care might then not be eligible for posthospital followup care from us and might have to be referred to some other system.

Chairman SIMPSON. Well, why don't you break it down for me and furnish what you can on any basis.

Dr. BROWN. We'll be glad to do that for the record if we may. There may well be impacts, for example, on training. I would like to have the opportunity to think it through and provide an answer for the record, if we may.

Chairman SIMPSON. Well, we are all interested, in formulating possible alternatives, if that is possible, whereby the VA health-care system can best serve those veterans who require health care. None of us wish to deviate from that.

[Subsequently, the Veterans' Administration submitted the following information:]

Should eligibility for VA health care become limited to inpatient services only, several patient care implications could be expected, as follows: delayed care, necessitating increased length of stay; increased morbidity (and possibly mortality); higher overall cost; lowered quality of care, with potential medico-legal ramifications.

Thus, it is reasonable to expect that the desired effect of restricting eligibility—cost containment—would be frustrated by this approach. Cost would likely be shifted from one account to another, while quality undoubtedly would suffer.

Chairman SIMPSON. But, let me ask you about three proposals which have been presented. Each have made an attempt to adjust the number of requests made for VA outpatient health-care treatment. One would have a type of copayment or cost-sharing initiative for every outpatient health-care episode or treatment for non-service-connected, nonpensioned eligible veterans. I would like your comments on that.

And then a second one that has been discussed would mandate that the VA bill medicare, workmen's comp, or any other alternative health insurance plan for any outpatient services provided to non-service-connected and nonpensioned eligible veterans.

And a third one stirring would provide a minimum level of eligibility for certain VA outpatient health services and benefits such as beneficiary travel, over-the-counter medicines, dental care, prothetics, and so on, for non-service-connected veterans not in receipt of pension.

And your comments please on those three ideas.

Dr. BROWN. Ms. Quandt.

Ms. QUANDT. There have been, as you say, Mr. Chairman, several previous requests to study copayment or collection from other Federal agencies. There is one major basic problem for the agency that creates for us an automatic request for increased funds: We lack the manpower at the present time for copayment, for billing of medicare, to assume those just paper processing activities. It would

mean essentially an add-on of $22.5 million in payrolls for the various people to do that work, plus the startup costs for an automated information system to process the bills, and all the tangential costs of stationery for billing and postage.

In addition, we have the problem that our track record on collection, because of the income level of our patients, is such that if we were to say that we would recoup, for example, $150 million, our rates of collection is 31 percent or less. So what you would be assuming would be saved is not going to be saved. And costs would have been expended by the agency.

We are then faced with other problems that would come about such as if we did have a user fee or copayment, if the patient didn't pay the first time and became ill and came back, are we to refuse that person admission? There become some rather grave medical ethics questions involved with this practice or policy.

As far as billing medicare and office of worker's compensation, we are able to reclaim funds from worker's compensation, and this is done with the help of VA district counsels. In only one area are we recouping funds at the present time from medicare and that is for hemodialysis patients.

Again, we come to what I believe has been the legislative history when such proposals have been made that while it is a matter of the same Federal dollars, it has been looked at in the past as an erosion of the Department of Medicine and Surgery.

We can do the billing but it will require that the agency request additional staff.

[Subsequently, the Veterans' Administration submitted the following information:]

During fiscal year 1981, DM&S facilities treated approximately 252,000 cases which were potential collectibles under either the tort feasor, Workers' Compensation, or third party insured criteria. Nearly all (242,000) of these cases were disclaimed for payment. The remainder, plus those pending from prior periods, were 33,000 cases, representing about $103 million in value. The total amount collected on these billings was $12,305,313, which cleared 7,470 cases. This is a recovery rate of 22.6 percent if based on bills paid, or 11.9 percent if based on dollar recoupment.

Chairman SIMPSON. Do you have any comment on any part of those other proposals other than the fact that it will cost more money to do?

Ms. QUANDT. Yes, we want to address the problem of beneficiary travel which has been increasing greatly each year.

Chairman SIMPSON. What is the figure right now?

Ms. QUANDT. For fiscal year 1982, we are budgeted at $82 million and we are probably on an actual basis closer to $72 million. Our field facilities have taken every administrative measure possible to restrain that cost. And I think I am not saying something unrealistic that we have a fear that some of them are outright denying a benefit to veterans who currently have it under the law in order to keep that cost down. Therefore, we have, ourselves, thought of proposed changes in eligibility; that is the one addressed in Dr. Brown's statement.

Chairman SIMPSON. One of the subjects that I didn't address in my letter of invitation on the hearing was the issue of fee-basis care for outpatients. That wasn't raised but I do want to understand the impact of the large number of veterans who are provided

outpatient visits on a fee-for-service basis. And I think that is in your realm, Ms. Quandt.

How does the VA justify providing so many service-connected veterans or veterans in receipt of aid and attendance or housebound benefits with fee-basis services instead of requiring treatment at a VA facility?

Ms. QUANDT. There are eight reasons why a veteran, either service-connected or non-service-connected with pension, may have care on a fee basis. And I would like to supply those for the record in order to save time.

Of all the veterans who are either service-connected or non-service-connected with pension, we are covering only 7.7 percent for the eligible population at the present time. Our budget for fee basis went from 1 percent of the total DM&S budget in 1970 to 3 percent of the total DM&S budget in 1980. Based on fiscal year 1980 data the average number of visits are 3.93 at a cost of $265 a veteran, or an average cost per visit of $29.72.

One major reason to use fee basis is if the veteran is too ill to have to travel and if it is a hardship, or if it is going to cost us more money to put that patient in an ambulance and bring the patient into a VA facility. If I have to pay $150 for an ambulance I am throwing money away administratively compared to that treatment either on a short-term authorization or long-term authorization to have the veteran treated by a local facility.

The usage on fee basis varies very greatly by regions. And I would also like to present that to you for the record because it illustrates what is happening in the Sun Belt area where there is a major population, a large group eligible who use fewer visits than, say, region 4. We attempt through administrative reviews, through peer reviews by professional services staff and through our systematic external review program visits, to have some uniformity of practice.

[Subsequently, the Veterans' Administration submitted the following information:]

Eligibility:

There are eight (8) kinds of disorders which may be treated in the Fee Basis Medical Program:

1. Service-connected disorders in service-connected veterans.

2. Any disorder in a 50 percent or greater service-connected veteran.

3. Any disorder in a veteran in an approved rehabilitation program (see U.S.C. 38, Chapter 31).

4. The disorder for which a veteran was hospitalized in a VA hospital.

5. Emergencies in veterans in VA hospitals where the VA hospital cannot provide the required care.

6. Emergencies in veterans in VA outpatient programs where the VA hospital cannot provide the required care.

7. Any nonservice-connected medical disability in a Mexican Border, World War I, A&A, or permanently housebound veteran when a VA staff physician has determined that appropriate treatment in a VA facility is precluded.

8. Diagnostic services ordered by physically separate clinics.

Individual veterans who have one or more of the above eight disorders will be allowed to receive Fee Basis care if the VA is not capable of furnishing economical care due to geographic inaccessibility or if the VA is not capable of furnishing the required care or services. In practice, an eligible veteran will receive authorization for Fee Basis care if the VA cannot provide the care, or if the VA's apparent cost of transporting the veteran to the VA exceeds the Fee Basis cost of care.

Long-term Fee Basis care is authorized for a defined period of time at the end of which the requirement for continuing the care should be reviewed. The VA may bring the veteran into a VA facility for reevaluation.

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Populations and Fee Medicine Penetrations by Geography
FY '80

State		Veteran Pop(000) SC	NSCP	Sum	No. of Fee Veterans	Fee Veterans/ 1000 SC + NSCP
PR	Puerto Rico	20.3	12.1	32.4	14,403	444.53
AK	Alaska	3.1	0.3	3.4	1,022	326.52
ND	North Dakota	5.6	2.2	7.8	2,521	323.21
HI	Hawaii	7.9	1.1	9.0	1,988	220.89
MT	Montana	8.3	3.7	12.0	2,370	197.50
ID	Idaho	8.6	3.7	12.3	2,212	179.84
FL	Florida	130.4	52.7	183.1	29,856	163.06
OK	Oklahoma	37.0	19.8	56.8	8,936	157.32
ME	Maine	13.3	7.7	21.0	2,767	131.76
NM	New Mexico	16.6	6.5	23.1	1,752	129.78
RI	Rhode Island	13.8	4.3	18.1	2,193	121.16
NV	Nevada	9.3	2.6	11.9	1,432	120.34
VT	Vermont	4.9	2.5	7.4	867	117.16
AR	Arkansas	26.7	20.7	47.4	5,249	110.74
AL	Alabama	40.3	21.2	61.5	6,763	109.97
OR	Oregon	25.8	13.6	39.4	4,329	109.87
SD	South Dakota	6.4	4.5	10.9	1,171	107.43
WA	Washington	45.2	13.5	58.7	6,160	104.94
AZ	Arizona	32.1	10.1	42.2	4,366	103.46
NH	New Hampshire	11.6	4.1	15.7	1,536	97.83
VA	Virginia	54.8	23.3	78.1	7,239	92.69
NC	North Carolina	52.6	32.9	85.5	7,912	92.54
WV	West Virginia	20.6	13.7	34.3	3,149	91.81
TX	Texas	146.4	65.6	212.0	19,098	90.08
GA	Georgia	51.9	29.5	81.4	6,752	82.95
IO	Iowa	22.4	12.3	34.7	2,860	82.42
NB	Nebraska	13.6	6.4	20.0	1,623	81.15
LA	Louisiana	34.8	22.9	57.7	4,391	76.10
PA	Pennsylvania	126.4	50.0	176.4	13,393	75.92
WI	Wisconsin	41.2	19.2	61.4	4,561	75.51
MS	Mississippi	24.5	20.2	44.7	3,291	73.62
UT	Utah	10.9	2.6	13.5	992	73.48
WY	Wyoming	4.1	1.6	5.7	406	71.23
MO	Missouri	43.1	26.8	69.9	4,942	70.70
MN	Minnesota	41.1	16.9	58.0	3,857	66.50
OH	Ohio	104.7	38.6	143.3	8,640	60.29
CA	California	202.5	79.8	282.3	16,598	58.80
SC	South Carolina	25.4	16.6	42.0	2,463	58.64
CO	Colorado	30.6	7.5	38.1	2,179	57.19
IN	Indiana	41.9	19.3	61.2	3,487	56.98
TN	Tennessee	40.1	29.6	69.7	3,869	55.51
KS	Kansas	20.8	10.2	31.0	1,691	54.74
MI	Michigan	83.0	25.9	108.9	5,707	52.49
KY	Kentucky	34.2	23.5	57.7	2,178	37.75
DE	Delaware	5.7	1.8	7.5	239	31.87
IL	Illinois	72.3	34.1	106.4	3,313	31.14
CT	Connecticut	30.2	7.7	37.9	1,081	28.52
NY	New York	182.8	65.3	248.1	7,066	28.48
MA	Massachusetts	94.2	21.5	115.7	2,221	19.20
NJ	New Jersey	78.2	20.7	98.9	1,841	18.61
MD	Maryland	38.1	11.8	49.9	924	18.52
DC	District of Columbia	8.0	3.0	11.0	164	14.91

FY 80 Facility Fee Utilization Rates Per Fee Veteran

District	Facility	No. of Veterans	Visits/ Veteran	Per Veteran Cost		
				Provider	Travel	Pharmacy
27	Honolulu	1,988	4.43	$125.69	$3.82	
27	Reno, NV	1,432	4.68	$134.41	$0.77	$1.47
27	San Francisco, CA	11,059	13.86	$469.93	$0.95	$22.53
28	Boise, ID	2,212	6.86	$194.70	$2.08	$16.91
28	Portland, OR	4,329	10.61	$331.87	$1.92	$58.92
28	Seattle, WA	6,160	5.91	$167.47	$0.91	$11.27
28	Anchorage, AK	1,022	4.07	$224.96		$29.72

Charts 1 through 4 summarize the differences in penetration, utilization, and expenditures by Region in the VA as reported by the Austin Data Processing Center. In the Great Lakes Region, 4.9 percent of the service-connected and pensioner population is cared for in the outpatient fee program. Each veteran in this program in the Great Lakes Region uses 11.51 visits per participant on the average. Each participant receives, on the average, $325.62 worth of ambulatory care, travel and pharmaceuticals per year through this program. At the other end of the scale is the Southeastern Region. Here, 11.2 percent of the highly eligible population is in the Fee outpatient program using 6.89 visits per participant at an annual VA cost of $235.07.

The nationwide average Fee Basis outpatient visit rate of 8.93 visits per person is higher than the average VA Staff utilization of 5.6 visits per person. The ambulatory care costs per participant of $265.47 per year is about $100 lower than the VA Staff ambulatory care costs per person per year of $363. While the national averages suggest that the program is fulfilling its purpose, there are large differences across the Regions. These large regional differences in market penetration, utilization and costs suggest that there is a significant difference in the use of the Fee outpatient programs.

Chart 1

FY 80
Outpatient Fee Program
Summary by Region

Location	% of Eligible Population(1)	# Visits per Vet(2)	Cost(3) per Vet	Cost(3) per Visit
Region 1 (Northeastern)	6.4%	11.64	$315.10	$27.07
Region 2 (Mid-Atlantic)	5.8%	9.61	$268.09	$27.90
Region 3 (Southeastern)	11.2%	6.89	$235.07	$34.12
Region 4 (Great Lakes)	4.9%	11.51	$325.62	$28.29
Region 5 (Midwestern)	9.3%	6.38	$162.50	$25.47
Region 6 (Western)	9.1%	9.96	$340.75	$34.21
U.S.A.	7.7%	8.93	$265.47	$29.72

(1) 100*(# of Fee Basis veterans)/(Service-connected + Pensioners)
(2) Vet = # of Fee Basis veterans
(3) Cost includes travel and Fee pharmacy

Chart 2

FY 80
Outpatient Fee Program
Regional Comparisons

Average costs per person treated
by Region in dollars

	Reg. 1	Reg. 2	Reg. 3	Reg. 4	Reg. 5	Reg. 6	VA
C&P Exams	3.69	7.29	15.11	2.91	12.00	15.87	10.81
10-10 Exams	15.68	1.90	0.71	0.03	1.15	3.33	3.26
Insurance Exams	1.11	0.0	0.0	0.0	0.0	0.26	0.19
Service-connected	230.45	172.35	128.03	198.53	86.89	214.60	162.77
Aid and Attendance	21.54	22.87	21.89	39.18	20.50	43.74	29.05
Nonservice-connected	26.31	16.19	4.42	14.04	23.87	27.56	17.68
Miscellaneous	0.21	0.14	1.25	0.95	0.94	2.34	1.06
Travel	3.73	3.04	2.43	3.18	1.57	1.57	2.46
Pharmacy	12.04	33.15	61.22	67.21	15.42	31.87	37.96
Totals	314.76	267.93	235.06	326.03	162.34	341.14	265.25

Note: Costs = (Category costs)/(Number of Fee patients in the Region)

Source: COIN OPF32, Report 70008. Fee Veterans and Costs by Region, Nation and Purpose of Visit. Fiscal Year 1980. RCS 10-69.

Chart 3

FY 80
Outpatient Fee Program
Category Specific costs per person treated
by Region in dollars

	Reg. 1	Reg. 2	Reg. 3	Reg. 4	Reg. 5	Reg. 6	VA
C&P Exams	45.30	35.69	49.25	49.85	37.17	47.95	44.19
10-10 Exams	73.46	558.42	111.25	133.00	94.77	113.80	88.51
Insurance Exams	83.29	39.50	29.00	NONE	NONE	161.96	93.62
Service-connected	370.42	257.11	213.26	245.55	161.17	391.82	264.83
Aid and Attendance	643.72	328.89	222.02	401.72	226.49	666.37	347.23
Nonservice-connected	122.46	497.87	600.95	407.50	447.21	712.84	545.26
Miscellaneous	86.49	88.65	131.36	109.16	63.38	127.66	106.61
Travel	50.05	66.31	60.10	73.72	70.56	84.91	63.56
Pharmacy	71.47	152.53	159.06	146.13	88.22	144.86	138.79

Note: Costs = (category cost)/(number of people in the category)

Source: COIN OPF32, Report 70008. Fee Veterans and Costs by Region, Nation and Purpose of Visit. Fiscal Year 1980. RCS 10-69.

Chart 4

FY 80
Outpatient Fee Program
Percent Population Distribution
by category within Regions

	Reg. 1	Reg. 2	Reg. 3	Reg. 4	Reg. 5	Reg. 6	VA
C&P Exams	8.2	20.4	30.7	5.8	32.3	33.1	24.5
10-10 Exams	21.3	0.3	0.6	0.0	1.2	2.9	3.7
Insurance Exams	1.3	0.0	0.0	NONE	NONE	0.2	0.2
Service-connected	62.2	67.0	60.0	80.9	53.9	54.8	61.5
Aid and Attendance	3.3	10.3	9.9	9.8	9.1	6.6	8.4
Nonservice-connected	21.5	3.3	0.7	3.4	5.3	3.9	5.5
Miscellaneous	0.2	0.2	0.9	0.9	1.5	1.8	1.0
Travel	7.5	4.6	4.0	4.3	2.2	1.8	3.9
Pharmacy	16.8	21.7	38.5	46.0	17.5	22.0	27.3

Note: Percent = (Number of people in the category)/(number of people in the region)

Total percents will not add to 100. One person may be counted in several categories.

Source: COIN OPF32, Report 70008. Fee Veterans and Costs by Region, Nation and Purpose of Visit. Fiscal Year 1980. RCS 10-69.

Clinic of Jurisdiction

FY 80 Facility Fee Utilization Rates Per Fee Veteran

Dis-trict	Facility	No. of Veterans	Visits/ Veteran	Per Veteran Costs Provider	Travel	Pharmacy
1	Boston OPC, MA	2,221	22.63	$556.76	$2.09	$29.72
1	Manchester, NH	1,536	9.08	$212.03	$3.36	$6.22
1	Providence, RI	2,193	6.59	$168.60	$1.65	$10.84
1	Togus, ME	2,767	8.58	$167.25	$3.08	$22.12
1	White River Junction, VT	867	11.61	$255.91	$3.10	$1.79
2	Albany, NY	1,508	16.63	$527.59	$11.00	$37.41
2	Bath, NY	88	8.77	$199.69	$11.32	$75.35
2	Buffalo, NY	1,320	17.90	$556.09	$6.70	
2	Syracuse, NY	2,988	16.95	$397.27	$3.30	$37.16
3	Brooklyn, NY	132	32.80	$1,013.65	$2.33	
3	Newington, CT	1,081	34.00	$812.85	$7.10	$23.35
3	New York, NY	1,030	22.81	$724.62	$5.48	$15.49
3	San Juan, PR	14,403	6.38	$165.12	$3.16	
4	Coatesville, PA	197	17.59	$398.82	$2.91	$15.68
4	Lebanon, PA	2,152	12.45	$250.89	$2.39	$53.65
4	Philadelphia, PA	4,616	13.35	$363.43	$0.48	$56.67
4	Wilkes-Barre, PA	2,273	13.14	$317.55	$3.67	$82.16
4	Wilmington, DE	239	13.13	$256.90	$0.52	
4	Newark, NJ	1,841	21.12	$534.70	$5.07	$34.57
5	Altoona, PA	1,229	10.59	$219.04	$8.21	$48.97
5	Butler, PA	386	10.59	$499.53	$2.83	$1.59
5	Erie, PA	308	11.19	$282.70	$0.32	$8.51
5	Pittsburgh, PA	2,232	5.10	$159.61	$0.73	$4.05
6	Baltimore, MD	924	8.62	$224.43	$2.39	
6	Martinsburg, WV	289	8.70	$143.25	$3.27	$18.66
6	Washington, DC	164	24.30	$525.22		
7	Huntington, WV	2,860	6.03	$153.58	$4.93	$9.09
7	Salem, VA	7,239	5.93	$123.28	$2.43	$10.60
8	Winston-Salem, NC	7,912	7.77	$181.06	$4.14	$44.93
9	Columbia, SC	2,463	11.06	$317.37	$4.56	$73.28
9	Decatur, GA	6,752	6.88	$154.42	$2.64	$114.17
10	Jackson, MS	3,291	7.68	$140.70	$1.65	$42.49
10	Montgomery, AL	6,763	5.43	$139.55	$3.32	$73.14
11	Louisville, KY	2,178	7.44	$147.43	$4.11	$14.60
11	Nashville, TN	3,869	5.31	$118.34	$2.81	
12	St. Petersburg, FL	29,856	5.97	$164.50	$1.68	$60.02

FY 80 Facility Fee Utilization Rates Per Fee Veteran

District	Facility	No. Of Veterans	Visits/ Veteran	Per Veteran Costs Provider	Travel	Pharmacy
13	Cincinnati, OH	2,316	6.69	$145.38	$1.32	$18.83
13	Columbus, OH	2,469	10.09	$258.86	$2.89	$120.72
13	Brecksville, OH	3,855	13.70	$287.76	$1.88	$101.30
14	Allen Park, MI	5,003	9.07	$198.52	$4.07	$92.45
15	Indianapolis, IN	3,487	16.66	$247.73	$2.95	$12.76
16	Iron Mountain, MI	704	6.67	$122.79	$4.90	$25.54
16	Wood, WI	4,561	10.03	$248.44	$3.51	$53.66
17	Chicago, IL	3,313	16.17	$441.94	$3.73	$75.75
18	Fargo, ND	2,521	6.52	$164.53	$2.60	$20.23
18	Minneapolis, MN	3,857	10.96	$267.26	$2.53	$19.41
18	Sioux Falls, SD	1,171	6.34	$122.77	$2.05	$2.43
19	Little Rock, AR	5,249	7.64	$176.98	$2.06	$33.87
19	New Orleans, LA	2,498	16.30	$367.88	$3.28	$89.53
19	Shreveport, LA	1,893	6.86	$169.78	$6.04	$79.33
20	Dallas, TX	10,867	4.02	$71.99	$0.38	$0.48
20	Houston, TX	585	17.28	$454.26	$4.20	$36.32
20	Muskogee, OK	8,936	2.96	$80.02	$0.66	$0.69
20	San Antonio, TX	1,549	6.86	$146.07	$0.53	$35.84
20	Waco, TX	2,043	7.29	$147.51	$1.60	$2.78
21	St. Louis, MO	1,302	7.68	$133.41	$4.58	$45.74
22	Kansas City, MO	3,640	6.99	$160.04	$2.30	$82.57
22	Wichita, KA	1,691	8.82	$177.10	$4.06	$43.76
23	Des Moines, IO	2,860	8.33	$148.27	$0.88	$10.13
23	Lincoln, NB	1,623	7.67	$157.27	$4.42	$3.35
24	Cheyenne, WY	406	9.16	$222.63	$3.60	$4.84
24	Denver, CO	2,179	7.57	$220.56	$0.70	$6.73
24	Ft. Harrison, MT.	2,370	9.33	$248.24	$4.16	$33.24
24	Salt Lake City, UT	992	9.57	$224.96	$0.94	
25	Albuquerque, NM	1,752	12.16	$331.68	$1.88	$7.40
25	El Paso, TX	1,606	7.79	$201.89	$3.26	$1.12
25	Lubbock, TX	2,448	7.01	$163.36	$1.77	$3.65
25	Phoenix, AZ	4,366	4.74	$116.83	$0.43	$1.61
26	Los Angeles, CA	4,998	16.73	$513.11	$3.68	$135.85
26	San Diego, CA	541	17.69	$531.40	$9.48	$70.55

Chairman SIMPSON. I just wonder who makes the decision to provide fee basis care? I have an understanding that except for one or two areas that it is not made by a physician. How does someone other than a physician make that determination?

Ms. QUANDT. The initial determination as to fee basis and whether or not a patient may have it is made in conjunction with a physician. It cannot be authorized unless the physician approves. After that the program runs very automatically. Our entire non-VA health-care program is operated by 663 employees across the country. It is such an automatic review that it is ordinarily handled in medical administration.

We are attempting to establish through program, policy, and procedural revisions the kinds of practice that we have found in VAMC's San Antonio, Denver, Phoenix, and San Diego. In these medical centers a physician is assigned that responsibility to carry on an ongoing review of patients' care and discusses cases regularly with fee-basis providers.

You will find the same thing happening in Florida. Florida must do it because of the pressure of cases.

Chairman SIMPSON. I have several other questions but because of time I will submit those in writing. But I would like to inquire how much truth there is to the need for a VA hospital director to, say, keep the beds full whether patients might need that actual hospitalization or not in order not to lose the valuable FTEE ratings. And if that is true, are there ways to provide more assurance of continued personnel resources without admitting patients who do not really need inpatient care?

It is apparent and very real that fiscal resources for outpatient care are dependent upon inpatient-based staffing ratios. And if outpatient medical care were to become more efficient and possibly reduce that need for some inpatient care, that would seem to then reduce the resources that would be available to the outpatient programs. Would that be the case? If so, what could be done to more effectively separate the needs of outpatient service and that of inpatient service and stop the use of FTEE ratings in order that resources will not be trimmed?

Ms. QUANDT. If I may answer, Mr. Chairman, as a former medical center director, it is a myth that has existed since approximately 1965 that the bed census drives the budget. While it is true that the bulk of the staff is related to inpatient care, it is no longer true, and it has not been true since the famous so-called "Skouge formula," that the bed census controlled whether or not you retained staff and dollars.

There is at the time, and should be at the time, no reason to retain patients in the hospital in order to keep your budget or your primary fund allocations. In fact, you can drop that census, move patients to ambulatory care, and given an increased workload you will retain your staff and you will retain budget.

Chairman SIMPSON. Perhaps you are right that the bed census doesn't drive the budget, but the bed census drives the Congress, I think. We wouldn't have done what we have done in the past.

I appreciate very much your participation. Thank you very much. You are always very helpful.

[The prepared statement of Dr. D. Earl Brown, Acting Associate Deputy Chief Medical Director, Veterans' Administration, and the VA's responses to written questions submitted by Hon. Alan K. Simpson, chairman of the Senate Committee on Veterans' Affairs, and Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs, follow:]

PREPARED STATEMENT OF DR. D. EARL BROWN, ACTING ASSOCIATE DEPUTY CHIEF MEDICAL DIRECTOR, VETERANS' ADMINISTRATION

Mr. Chairman and Members of the Committee:

I am pleased to be here today to discuss the Veterans Administration's outpatient health care program. Mr. Chairman, we believe our ambulatory care program has been and is a successful means of providing appropriate and cost-effective care to eligible veterans with minimal disruption of their activities of daily living. Since the eligibility for services and the modes for providing care to veterans are governed in large part by statutory provisions, the growth in the VA outpatient program has been significantly influenced by legislative action.

The passage of Public Law 93-82 in August 1973 established the nonservice-connected veteran's eligibility for outpatient care to "obviate" the need for hospital admission. As a result of this act, our outpatient program grew dramatically in the three-year period from 1973 to 1976. This enormous increase in the number of outpatient visits during this period created serious problems in virtually every outpatient facility in the VA system. None of

these facilities was originally built for the purpose of providing ambulatory care to any great extent and the rapid changes thrust upon the system were difficult to accommodate within a fixed resource base. Although these changes produced strain it should be pointed out that the growth in ambulatory health care had a significant impact on reducing the requirements for inpatient health care.

The Congress was aware of this growth in our outpatient program and in 1976 enacted legislation (P.L. 94-581) which required that outpatient care be furnished in accordance with a statutory priority scheme. That act not only established the concept of priorities for care but also provided the VA with a mechanism to adjust access to services based on VA's resources to provide outpatient care. As a result, our current instructions advise each medical facility director:

> "When the demand for care is consistently greater than the care which can be provided with available VA resources, restrictions on accepting new outpatients will be imposed by the health care facility director. In such event, admission of applicants to outpatient programs will be restricted by not accepting applicants from priority categories below the priority level where appropriate care can be provided within available resources. These restrictions may be applied by clinical subspecialty or service.... Applicants who cannot be accepted for outpatient services will be referred to Social Work Service for review and counseling regarding the use of non-VA health care resources."

Since that time, much management attention has been given to assuring the most effective and efficient use of limited outpatient resources. Constant monitoring of this program has produced efficiencies that have allowed us, at least in part, to accommodate additional workloads

that have resulted from subsequent legislative initiatives which expanded eligibility for outpatient care to new groups of veterans. We are not able to meet all the demands for outpatient care that are placed on the system, however. Our facility directors have and continue to exercise the authority given to them to restrict the eligibility for outpatient services to lower priority groups of veterans to varying degrees all over the country.

Mr. Chairman, in your letter to us regarding this hearing you raised the issue of the system's ability to adjust to meet changing and increasing demands for outpatient care in the future particularly as related to the aging veteran population. With the aging of World War II and Korean conflict veterans, VA and the Congress are presented with major planning and policy questions. Within some 15 years, approximately 9 million of these veterans will be 65 years of age or older. This aging population can be expected to experience a naturally increasing risk of disease as aging proceeds. We would similarly anticipate that they will have an increased need for a wide variety of health care services, including outpatient care.

Is the VA outpatient system presently equipped to adapt to the unique and rapidly growing needs of the aging veteran population during the next decade, and can it do so within present fiscal constraints? One man's brief answer to that question might be "Yes, but...!".

We believe that the VA has the capacity to adapt to this phenomenon, and that the key to such adaptation lies in the planning process. We are very much engaged in that very process, but: it would be misleading of us to suggest that the current magnitude of resources will permit us to furnish all the care this older population will need.

By way of background, it may be helpful to clarify the nature of the 65-year old veteran's eligibility for outpatient care. It is important to note that the 65-year old nonservice-connected veteran of World War II or the Korean conflict is not eligible for comprehensive VA outpatient care. However, that individual is granted eligibility for certain outpatient services, without regard to ability to pay, by virtue of a provision which authorizes medical services to any veteran eligible for VA hospital care. As such, the 65-year old may be provided outpatient care in any of three modes--so-called "pre-, post-, or obviate care." That is, outpatient services may be provided (1) preparatory to hospital admission, (2) to complete treatment begun during hospitalization, and (3) to obviate the need of hospital admission. "Obviate" eligibility is statutorily qualified by the phrase "to the extent that the facilities are available;" accordingly treatment on this basis has the lowest priority. "Post-hospital" care is also limited by statute--to a period of up to a year after discharge, although a longer period may be authorized when needed.

Unlike other specified classes of veterans, the older veteran has no claim to priority in the provision of medical care. By virtue of his relatively low priority as against the several groups of veterans with such statutory standing, the 65-year old veteran might conceivably be denied access to outpatient care in certain areas based on resource constraints, albeit having eligibility.

In widely publicized remarks, the Administrator has called attention to the dimensions of the aging veteran issue. We believe the committee is taking an important step in addressing itself to this difficult subject. However, since veterans over the age of 65 are eligible for hospital, nursing home and domiciliary care, a balanced health care program should allow outpatient care to obviate the need for such hospitalization and to allow necessary pre- and post-hospital care to such patients.

Mr. Chairman, in inviting us to testify today you posed a number of issues. Among these, you asked us to discuss VA's provision of primary, chronic and acute health care in the outpatient setting.

In administering outpatient services, the VA does not categorize outpatient care as primary, chronic, and acute health care, although all three are to some extent provided in VA health care facilities, consistent with governing eligibility provisions. Statistics relating to those specific categories are not maintained, however.

Primary care is an approach to a patient rather than a medical condition. It is the evaluation and management of a patient by a broadly trained physician (usually a specialist in Internal Medicine or Family Practice) who may subsequently refer the patient to a medical subspecialist because of a need for more sophisticated expertise.

Both the primary care physician and the subspecialist are capable of treating either acute, sudden medical problems or chronic disease of longer duration.

The outpatient department of our health care facilities serves as the entry point for all veterans seeking treatment. In many cases the medical needs of a veteran whether the problem is acute or chronic may be met most appropriately, and cost-effectively, in an outpatient setting, thus obviating the need for more expensive hospitalization. By focusing subspecialty expertise in well-equipped, modern ambulatory care facilities a wide variety of consultants and specialty procedures are readily available to both inpatients and outpatients. It is not uncommon for an outpatient to be seen by many subspecialists during the course of his or her outpatient treatment. Thus, VA ambulatory care services provide a broad spectrum of care for patients with acute and chronic medical problems whether these patients are seen by primary care or highly specialized physicians.

Resource Allocation

Among the complex challenges we face in administering the VA health care system is the matter of allocating resources. Our resource allocation method gives consideration to both inpatient and outpatient workloads as well as individual needs of a particular facility. By doing so, the system reacts to the changing geographic and demographic situation throughout the country. Funding levels and the size of new facilities are based on the latest available demographic studies. Past projections were based in large part on the 1970 census data. However, 1980 census figures, which will certainly reflect increased population in our nation's "sun belt" regions, will undoubtedly require that we alter the distribution of VA resources.

Individual facility directors are expected to accomplish the mission of their facility within the funding level distributed, and subsequently adjusted, on their "Target Allowance." The specific allocation of resources to outpatient care is made by the local facility director. Our resource allocation methods do provide a measure of flexibility: Regional Directors have discretion to make funding adjustments for workload and other changes during the distribution of the Target Allowance and at other times during the fiscal year. This mechanism has allowed the system to respond to the grass roots identification of needs and the availability of funds.

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As you know, the MEDIPP (Medical District Initiated Program Planning) which was recently initiated represents an effort to develop a more systematic, refined resource distribution and control system. A central feature of the MEDIPP process is its reliance on demographic analysis at the local facility level to develop future plans. We believe this planning initiative, coupled with other strategic management initiatives currently being developed, will yield an improved basis for equitable allocation of resources.

Women Veterans

Consistent with the increase in the percentage of women in today's Armed Forces, the number of women veterans will continue to increase. In 1970, women constituted 1.9 percent of the veteran population; in 1979, it was 2.3 percent and in 1981 it was 2.5 percent. The largest number of women veterans are World War II veterans (289,000) closely followed by Vietnam veterans (188,000). Female veterans also tend to be younger than male veterans.

In FY 1981, women veterans represented 1.7 percent of the hospital workload, 2.3 percent of the nursing home workload and 1.3 percent of the domiciliary workload. Unfortunately, we do not maintain data on the percentage of outpatient visits made by women veterans.

Female Vietnam veterans now average 30 years of age. Within the next 20 years this age group may be expected to develop gynecological

problems in addition to the normal range of other medical problems. The demand for medical care for female-related medical conditions will also increase as spouses eligible for CHAMPVA apply for medical care in VA facilities. We believe that we currently have adequate flexibility to meet the needs of our female veterans.

Over-the-Counter Medicines

Mr. Chairman, in your letter to the VA requesting testimony for this hearing, you raised the issue of the provision of over-the-counter medicines to veteran patients. Legislation was considered by the 96th Congress that would have restricted the use of over-the-counter medications for nonservice-connected veterans. Although this legislation passed the Senate in 1979, it did not pass the House and report language accompanying P. L. 96-151 expressed the views that the VA already has the flexibility to curtail the use of over-the-counter medicines if it so desires. A resources adjustment to the VA budget was made at that time as a result. Although we have no Agency position to offer on legislation of this nature, we would point out that over-the-counter medications are just as much a part of a patient's treatment as are prescription medications. An example is the use of insulin for the treatment of diabetes. We would note that imposing limitations on the over-the-counter drugs for certain categories of patients would not necessarily inhibit physicians from prescribing a more expensive legend drug, where available, to take the place of an over-the-counter drug.

Beneficiary Travel

Mr. Chairman, you asked us to comment on the appropriateness of continuing to provide beneficiary travel payments to nonservice-connected veterans.

It is noteworthy that the VA, unlike any comparable health care delivery or financing system, reimburses many of its health care beneficiaries for the expenses of travel to and from its medical facilities. We believe, however, that the cost effectiveness of this benefit in the current budgetary environment must be seriously questioned, and that further reductions in the payment of such benefits are desirable.

We must advise you that there is a difference of opinion within the Administration as to the VA's authority to achieve further savings through administrative measures alone. The General Counsel of OMB has expressed the opinion that the VA already has the necessary discretionary authority to curtail payment of beneficiary travel without the need for further legislation. Our General Counsel disagrees. We intend to submit this difference of opinion to the Attorney General for resolution. In the meantime, however, and to ensure that the savings in beneficiary travel benefits which the Administration believes to be desirable are realized, we are requesting that you introduce and favorably consider legislation which will clarify our authority to limit the circumstances under which veterans receiving VA care, treatment, or examinations for

nonservice-connected conditions are authorized to be reimbursed for travel expenses to and from the VA. This legislation, which we will soon submit to you, would generally curtail payments for travel in connection with VA care of veterans' nonservice-connected conditions. The bill would still permit reimbursement for travel to VA health facilities for veterans receiving care, treatment, or examination in connection with vocational rehabilitation or for a service-connected disability, veterans 50 percent or more service-connected disabled, and VA pension recipients. The draft bill would also authorize the Administrator to prescribe regulations to provide for patients' transportation in emergencies and to permit transfer between facilities of a veteran already receiving VA hospital or nursing home care.

Our proposed restructuring of the beneficiary travel program would diminish its annual cost by some $30.7 million for each of the first five years.

Mr. Chairman, that concludes my remarks. My colleagues and I will be pleased to respond to any questions you may have regarding these matters.

RESPONSE OF THE VETERANS' ADMINISTRATION TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN K. SIMPSON, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1A. As I stated at the beginning of the hearing today, as Chairman of the Senate Committee on Veterans' Affairs, I am interested in formulating alternatives, whereby the VA health-care system can best serve those veterans who need certain health care. Please comment on the three following proposals, each of which is an attempt to limit the number of requests made for VA outpatient health-care treatment:

1. To implement a type of co-payment, cost-sharing initiative for every outpatient health-care episode of treatment, for nonservice-connected, non-pensioned, eligible veterans;

Answer 1A. Copayment requirements in general tend to limit somewhat the number of requests for medical assistance made upon an outpatient care system. In an environment where the demand for VA outpatient care systemwide exceeds the system's capabilities, serious consideration should be given to such mechanisms as copayment requirements. Our limited study of this area suggests, however, that VA could experience relatively high costs in attempting to implement an effective copayment plan. Targeting copayments specifically to a population most of whom are eligible for care only on the basis of their inability to defray the cost of the needed services may also raise other problems. Funding for a study of this concept was included in the President's Fiscal Year 1983 Appropriation request to the Congress. With Congressional approval of these funds, we plan to study the copayment concept in greater depth.

Question 1B. To mandate the VA to bill Medicare, Workman's Compensation, or any other alternative health insurance plan for outpatient services provided to nonservice-connected, non-pensioned, eligible veterans.

Answer 1B. The VA now routinely bills for medical care provided veterans in tort feasor, workers' compensation, reimbursable insurance, uninsured motorists and crimes of personal violence cases. Public Law 97-72 provided statutory authority for recovery of the cost of medical care and services furnished for a nonservice-connected disability in three specific areas which will permit collection in those States where court decisions or State statutes previously denied reimbursement to a Federal medical facility.

The VA bills Medicare when emergency, humanitarian care is provided a nonveteran Medicare beneficiary. Medicare billing is also made when an ineligible person, provided care as a presumed veteran and later found ineligible, is known to be a Medicare beneficiary. The VA does not routinely bill Medicare for medical services provided nonservice-connected, non-pensioned veterans nor does the VA routinely bill CHAMPUS for medical services provided nonservice-connected military retirees. Medicare and CHAMPUS are not considered primary payers in such cases of dual entitlement. Consideration of a mandate for the VA to bill Medicare must be approached with the realization that acceptance of Medicare reimbursements could subject the VA health

care system to administrative requirements of the Department of HHS. The VA cost accounting system would have to comply with HHS requirements, and HHS may insist on conducting retrospective audits of the cost accounting records of individual VA health care facilities. Accepting payment from Medicare does not diminish the total budget, but takes dollars from another Agency and transfers them to VA. There would be an increased cost to the tax payer and VA in the form of administrative overhead. In addition to establishing billing-collection procedures, there would be an administrative fee. This probably would not be unlike CHAMPVA where we now pay an intermediary some $6 or $9 per claim for processing.

Most health insurance policies contain exclusion clauses to prohibit payment for medical care provided in Federal medical facilities. Legislation had been proposed in recent years to require removal of those exclusion clauses, but health insurance providers were extremely resistant to those proposals. Unless such legislation is enacted, no useful purpose would be served by billing alternative health insurance carriers for outpatient services provided to veterans.

Question 1C. To provide more limited, minimum levels of eligibility for certain VA outpatient health services and benefits, such as beneficiary travel, over-the-counter medicines, dental care, prosthetics, etc., for nonservice-connected veterans not in receipt of pensions.

Answer 1C. a. The VA is the only health care delivery system which reimburses many of its beneficiaries for the expenses of travel to and from its medical facilities. We have previously endorsed legislation which would generally curtail travel payments for veterans receiving care for NSC conditions.

b. Over-the-counter medicines are just as much a part of a patient's treatment as are prescription medications. Any limitations imposed on over-the-counter drugs for certain categories of patients would not necessarily inhibit physicians from prescribing a more expensive legend drug, where available, to take the place of the over-the-counter drug. Restrictions on over-the-counter medications may not necessarily prove to be cost effective.

c. The only nonservice-connected veterans who are entitled to outpatient dental treatment are certain former Prisoners of War and those NSC veterans whose dental treatment was begun during hospitalization because it was considered to be essential and related to their medical problems as inpatients, and to be completed following discharge. Restricting treatment to former POW's would have little if any effect. Restricting dental treatment for inpatients would inhibit the ability of physicians to treat veterans in situations where a determination has been made that certain dental treatment is a necessary part of treatment of the disability for which admission was authorized. More

limited eligibility for prosthetics likewise compromises the ability of the physician to treat veterans when a device is required as part of treatment, for post hospital care, or for eligible former Prisoners of War, or veterans of the Mexican border period or World War I, and produce little economical benefit.

METHODOLOGY

Personnel

172 Medical Centers

MAS	— 2.7 FTEE per facility @ GS-5/5	= $7,440,895
Fiscal	— 2.7 FTEE per facility @ GS-5/5	= 7,440,895
Social Work	— 1 FTEE per facility @ GS-12/5	= 6,056,895

56 Clinics

MAS	— 1 FTEE per facility @ GS-5/5	= $ 897,265
Fiscal	— 1 FTEE per facility @ GS-5/5	= 897,265
Social Work	— 1 FTEE per facility @ GS 12/5	= 1,972,000

Total Personnel Cost - $24,705,179

Mail

20-cent stamp for each mailing for 7.8 million visits amounts to $1,560,000 in mail costs.

Stationery

Stationery costs to include a standard billing form @ 15 cents per form will be $1,170,000.

ADP

Implementation Cost: $31,943,400 ADP Recurring Cost: $10,951,400

TOTAL COSTS:

Implementation - 1st Year - $59,378,579

Recurring Cost Each Additional Year - $38,386,579

Question 2. How would an expansion of Day Care Programs for Mental Health Services, Home Nursing Care, and Hospital Based Home Care (HBHC) Program affect the current demand for outpatient services?

Answer 2. At the present time, the VA has two types of day care programs serving primarily outpatients with psychiatric disorders. There are Day Treatment Centers and Day Hospital programs. There are currently 57 Day Treatment Centers and 40 Day Hospital programs. A brief description of each type of program is attached.

During FY 1981, the Day Treatment Centers generated 527,664 patient visits. Most of the patients seen in the Day Treatment Centers are service-connected (71 percent), and 39 percent of patients seen in Day Hospitals are service-connected.

The patient demand in both programs is increasing while efforts are being made to reduce the number of patients seen in order to approach the established staff to patient recommended ratios. Expansion of either or both programs would have to have increased staffing to meet their current workloads. Current recommendations are for 24 new Day Treatment Centers and 26 new Day Hospital programs.

Overall, as the potential needs for such outpatient psychiatric services are, for practical purposes, almost infinite, any

expansion of treatment capability will most probably just generate a greater demand for such services.

Referrals to the Hospital Based Home Care (HCHC) program are primarily from the hospital bed services. Only about 5 percent of the referrals are from the outpatient service. These referrals are for patients who have difficulty returning to the outpatient clinic on a regular, recurring basis because of long-term disabilities. Expansion of HBHC would not significantly affect the current demand for outpatient services.

In the home nursing program, health care services are purchased from community home health agencies on a fee-for-service basis. These services are usually purchased for patients who require short-term follow-up care at home following a period of hospitalization. The impact upon the demand for outpatient services would be minimal if the home nursing care program was expanded.

Attachment

By and large the attending veteran is seen as having the potential to return to his previous community role, or as being able to live in the community with his family, with some continuing support from the Mental Hygiene Clinic.

The basic staff unit consists of a psychiatrist, a psychologist, a social worker, and a clerk.

Day Treatment Center

Day Treatment Centers are established to provide an intermediary type of treatment for the chronic psychiatric patient with long residence in the hospital. They attempt to help the chronic patient handle most of the difficult problems he will encounter when trying once more to adapt to the social requirements of the community. Most of these patients have been ill for a long time, and they will require continuing encouragement to accept responsibility, to accept rehabilitation, and to improve their interpersonal skills.

In most instances the patient's mental condition is fixated at a level below that which he formerly had attained, and the forms of therapy at the clinic are largely supportive, aimed at basic social rehabilitation. In some instances, even work rehabilitation is possible. This type of patient will usually continue to need the daily or weekly support of the Day Treatment Center program for some time. Hopefully, such patients will eventually be able to attend a Mental Hygiene Clinic. The important point is that this continuing, long range supportive therapy can be carried out while the major part of the patient's time is with his family, with a foster family, or with a community group living arrangement.

The basic staff unit for a Day Treatment Center consists of five (5) FTE, i.e., a psychiatrist, a psychologist, a social worker, an occupational therapist, and a secretary.

Day Hospital

The Day Hospital program operates primarily to permit a patient to receive necessary treatment while continuing his community activities, thus hoping to overcome the need for hospitalization. This program may contribute to the earlier discharge of patients needing the intensive therapy and support available in such a setting when they no longer require the 24-hour structural supervision of a regular hospital program.

The patient is frequently acutely ill and the treatment orientation is crisis intervention. In addition to intensive outpatient treatment by all of the available modalities, the patient is able to maintain his contacts with the community since he is able to return to his family or friends at night. Some of the adverse effects of full-time long term hospitalization are thus avoided. Most of these patients have been ill for only a short time, and their prognosis is that they will soon return to their previous community status. After their period of day hospitalization, the patient is usually followed and supported by the Mental Hygiene Clinic.

The basic staff unit of a Day Hospital is composed of six (6) FTE. This includes a psychiatrist, a nurse, a psychologist, a social worker, an occupational therapist, and a secretary.

It should be emphasized that each of the three treatment programs require a basic multidisciplinary mental health team in order to provide the necessary range of professional skills and extent of required services.

2. As of August 16, 1973, the Mental Hygiene Clinic, Day Treatment Center, and Day Hospital programs were no longer designated as Specialized Medical Services within the Veterans Administration Department of Medicine and Surgery. Consequently, the mechanism for their development and implementation, formerly coordinated by Planning Service, has been revised. The remainder of this Circular is to acquaint you with these procedures and explain the part to be played by the hospitals and clinics who may wish to start such programs.

Question 3. In his testimony, Dr. Rodney Baker has pointed out that the lack of a sufficient management information system produces planning problems for Outpatient Directors and Hospital Directors. In what way will the new VA automated data processing (ADP) initiatives change this situation?

Answer 3. The presently-available management information system relating to outpatient visits (Outpatient Staff Visits) is derived from information taken from the Outpatient Routing Slip. The Outpatient Routing Slip is a document designed centrally and applied in all VA Medical Centers uniformly. A 20 percent sample of all such 'routing slips' is processed to create the database used primarily by management in the Central Office. Dr. Baker's concern is a legitimate one, and the new VA Decentralized Hospital Computer Program (DHCP) will ultimately accommodate his needs (and those of others in the field) through the ability, locally, to collect whatever outpatient-related data the individual Medical Center Directors as well as District, Regional, and VACO officials define as necessary. The Admissions/Discharge/Transfer modules to be put on-line at each facility will support this information requirement. Provision is made for sufficient local ADP capacity to be reserved for management information reporting required by the District, Region, and Central Office.

Question 4. Does MEDIPP participate in ADP planning initiatives?

Answer 4. The Administrator, in his Executive Order, has charged the Chief Medical Director to reorganize the Department's ADP planning functions, and to review and overhaul the DM&S management information system. In the Chief Medical Director's reorganization plan MEDIPP will participate in the identification, formulation, and design of data required for the conduct of its (MEDIPP's) planning responsibilities.

Question 5. In your view, how should the ADP capacity be readied to provide the type of management information needed to be helpful in planning for the future of the Ambulatory Care System?

Answer 5. Providing for the ADP capacity required by the Ambulatory Care System, as well as for those of all patient care programs, requires the prior assessment of program data needs. Such an assessment is presently underway, pursuant to the Administrator's charge to review and overhaul management information systems, and will lead directly to a quantitative statement of each programs's ADP capacity requirements. The summation of all program ADP capacity will define the systems' ADP capacity needs, and will be taken into account in planning for ADP hardware and software procurements to satisfy those needs.

Question 6. I have noted in looking at your report to Congress, required by P.L. 96-22, which outlines contract programs, that certain States, such as Texas, Arizona, Mississippi and Florida, seem to have a far greater proportion of veterans who have been provided with contract care. Will you please give me a breakdown of the kinds of disabilities these veterans have, especially in States with very large numbers of fee-for-service outpatient visits and reasons why these services could not be provided in house?

Answer 6. A breakdown of the kinds of disabilities being treated on fee-basis are not maintained in a computer-assisted system. Hence, this information cannot be provided to you. The kinds of disabilities of veterans authorized fee-basis care are recorded only in their medical records and on the ID cards issued to them to obtain the care. Only veterans who meet statutory requirements for fee-basis care are referred to extra-VA physicians, etc., for care.

Question 7. What are your views on eliminating the fee-basis program except in instances when it could be determined to be more cost effective or in emergency situations? Please explain to me the frequency and detail by which you reevaluate the need for fee-basis outpatient services for individual veterans?

Answer 7. Fee basis is one of several options to provide care to certain classes of veterans. It is used if there is not adequate, proper inhouse capability, or when cost of travel exceeds unit cost of care to be given by VA. Another factor is "humaneness", if the veteran is so debilitated that travel causes physical hardship. Each authorization for fee-basis care is only valid for a specified period of time, not to exceed 36 months. The need to transfer the veteran to care by VA staff, to extend the authorization validity period or to terminate the authorization must be determined by VA staff physician before the end of the authorized validity period. Each authorization must be reviewed at a minimum of every 36 months. These determinations are made by one, or a combination of the following: review of the veteran's medical records, consultation with the fee treating physician or examination of the veteran by VA staff physicians.

Question 8. Why are some States so much higher than other States in their average cost per visit in the fee-basis care? Does it have to do with local costs, or is it the type of care provided?

Answer 8. The average cost per visit in fee-basis care is based on local costs. The concentrations of older veteran populations in retirement centers, such as California, Florida and Texas, may be a factor in the higher cost per visit in such areas because of the nature of illnesses of older veterans.

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Question 9. Is there a breakdown of fee-basis by type of disability and number of visits for that disability which would also indicate when a reevaluation of this need occurred? If there isn't such data, what are your thoughts on generating data of this type in order to understand more completely when the fee-basis services are truly needed?

Answer 9. The computer-assisted system used to process payments for fee-basis care and to collect cost and workload data does not have the capability to generate information breaking down the types of disabilities and the number of visits in connection with types of disabilities. It does generate a list monthly identifying veterans whose fee-basis authorizations are due to expire 60 days from its date. This list is used at clinics of jurisdiction for reevaluation of these veterans' need for fee-basis care. This computer-assisted system has been considerably enhanced in recent years. The feasibility of adding to it the capability to generate data on the type of disability treated by each visit is now being studied. It would be very useful to have such data generated for determining need as well as evaluating the quality of care being provided on fee basis. This enhancement will be made to this system if it is determined to be economically feasible. We concur that more modifications are necessary in this data base.

Question 10. What percentage of nonservice-connected veterans in receipt of aid and attendance or housebound benefits are treated on a fee-for-service basis?

Answer 10. At the end of Fiscal Year 1981, there were a total of 136,279 nonservice-connected veterans in receipt of Aid and Attendance or Housebound awards (114,146 A&A and 22,133 Housebound). *

During Fiscal Year 1981, 17,024 of these veterans (12%) were provided fee-basis care. #

Source: DVB Printout of Pension Statistics for March 1982

Source: Fiscal Year 1981 data collected for RCS 13-50 report for Congress required by section 201(b), P.L. 96-22. Report was not submitted.

Question 11. Those veterans over 65 who are nonservice-connected have limited eligibility for outpatient health care. That is, they have low priority and are only eligible for Pre-hospital care, Post-hospital care, and services to obviate the need for hospital care. Nonetheless, these veterans are in the outpatient clinics receiving care for what, according to testimony, appear to be chronic problems. Do you have statistics which would tell us how many and what percentage of this category of eligibles currently are receiving such care and what percentage are receiving inpatient care?

Answer 11. In Fiscal Year 1981, 1,979,077 outpatient visits or 13 percent of the VA's outpatient workload were veterans age 65 and over. In providing outpatient services, the Agency does not distinguish in the level of care provided such as primary, acute, or chronic care and therefore statistics are not available which could assist us in determining the portion of the approximate two million outpatient visits required for chronic problems.

During this same fiscal year, nonservice-connected veterans over age 65 accounted for approximately 147,524 discharges or 15.7 percent of the total discharges from inpatient care. Available PTF (Patient Treatment File) data provide the statistical estimate of approximately 74 percent or 109,168 discharges of the 147,524 discharges were for the treatment of chronic conditions for these nonservice-connected veterans.

Question 12. Because of the limited eligibility of many nonservice-connected veterans, and because of their often chronic and multiple problems, do you find that physicians who need to make decisions which put them in what Dr. Baker says, "uncomfortable professional dilemmas" tend to treat all the veterans that they do see or perhaps more often hospitalize veterans unnecessarily and at greater costs, to get around the limits of their eligibility?

Answer 12. The eligibility of nonservice-connected veterans who have problems which require hospitalization but who can be treated under the "obviate the need" provision is restricted only by the cut-off point in the priority level at individual medical centers. That level is determined locally by availability of resources. If these veterans are sick enough to require hospitalization and the local priority level would not permit them to be treated as outpatients, good medical judgment would dictate hospitalization. Staffing and resource levels at VA facilities are such that medical staffs do not unnecessarily use a higher cost level of care. Our experience indicates most facilities strain outpatient care resources by adding cases, thus finding a way to provide care, and exceed workload. As a last resource, the veteran is rejected and sent elsewhere.

Question 13. There have been some references to a correlation between increasing resources for ambulatory care and a resulting reduction in need for inpatient treatment. Would you comment?

Answer 13. In the absence of ambulatory care resources, medical judgment will dictate admission rather than outpatient care. Outpatient treatment, which includes pre-bed care, post-hospital care (both SC and NSC), "obviate the need" care and "walk-in" (which population cannot be scheduled and therefore cannot be controlled), all require an expanded outpatient capacity and with it a need for adequate resources. By definition, the pre-bed care patients all will be admitted as inpatients. A significant number of "walk-ins" require direct admission for hospitalization; some are placed in the "obviate the need" category. Our experience with "obviate the need" outpatient care is that some patients can be sustained at a lower cost level. The growth in this program has also contributed to the system attaining a shorter average length of hospital stay. However, this has resulted in more complex acute care cases being admitted for inpatient care so that the proportion of inpatients requiring higher levels of nursing care has actively increased since enactment of P.L. 93-82.

Question 14. Do you believe that outpatient clinics should provide more emphasis on specialized services often associated with an ill, aging population, such as orthopedics, podiatrists, or dermatologists? to what extent is a change in this direction occurring or being discussed within the VA system?

Answer 14. The outpatient clinics in the Department of Medicine & Surgery provide, within the limits of resources, specialized outpatient services to those veterans seeking care and demonstrating illnesses that require such service. Planning presently under development in DM&S for future outpatient health care delivery is based on the projections of the utilization of services by different age groups, including those representing the ill, aging population. This planning, therefore, involves a consideration of the need for specialized services for this group and the specification of changes in outpatient services to accommodate the aging population workload. If these plans can be implemented within existing resources, further emphasis is probably not needed.

Question 15. The American Legion, in its testimony, requests that Congress mandate a study to determine the current anticipated demographic profile of the veteran population, and the present capacity of the VA to provide medical services to the ambulatory care program population. Is such a study necessary? Haven't such studies already been conducted and utilized by the VA? Please provide the results of these studies for the hearing record.

Answer 15. A demographic profile of the veteran population, based on preliminary 1980 census data, is being completed by means of a contractual agreement between the Department of Medicine and Surgery and the Applied Population Laboratory at the University of Wisconsin. The revised population statistics will be used in the recently-activated decentralized planning process to project the number of visits expected in VA outpatient clinics.

Question 16. What steps has the VA taken to ensure that veterans in all areas of the nation receive standardized, appropriate, quality health-care treatment?

Answer 16. The basic policy of the VA is to provide high quality medical care to both inpatients and outpatients. While ultimately Central Office is responsibile for quality of care throughout the system, each medical center director and chief of staff is responsible for assuring the day to day level of quality care for their facility. The Central Office Systematic External Review Program (SERP), as well as the Joint Commission on Accreditation of Hospitals (JCAH), periodically review the quality of care at each of our facilities. Currently, all of our facilities are JCAH accredited.

In areas not in proximity to VA facilities, such as a hospital or an outpatient clinic, the VA has established a fee-basis program for eligible veterans. This care is provided by a local physician of the veterans choice on a fee-for-service basis. This can occur if the VA cannot provide the required care or cannot do so economically because of geographic inaccessibility.

Question 17. Do veterans in different areas receive different levels of health services and benefits in terms of beneficiary travel, over-the-counter drugs, dental care, etc.?

Answer 17. The administration of benefits for eligible VA beneficiaries is guided by departmental policies with uniform application. Some variations may exist such as with beneficiary travel depending on the availability of commercial transportation or distances to be traveled in particular areas. The resources available at each facility will also impact on the administration of benefits as in providing medical and/or dental services to the lower priority category of beneficiary. However, the guidelines for providing or restricting services are provided in departmental policies applicable to the entire VA health care system.

Question 18. **What efforts are made to ensure that high quality medical care continues to be provided at VA Outpatient Clinics, given increased numbers of eligible veterans and decreased resources?**

Answer 18. **The basic policy of the VA is to provide high quality medical care to both inpatients and outpatients. While ultimately Central Office is responsible for quality of care throughout the system, each medical center director and chief of staff is responsible for assuring the day to day level of quality care for their facility. The Central Office Systematic External Review Program (SERP), as well as the Joint Commission on Accreditation of Hospitals (JCAH), periodically review the quality of care at each of our facilities. Currently, all of our facilities are JCAH accredited.**

Question 19. Are any studies now being conducted or planned by the VA on what effect changing Medicare and Medicaid health-care benefits will have on usage of the VA health-care system by eligible veterans?

Answer 19. We are currently studying the relationships between community specific demand and supply variables and VA utilization. We do not have access to variables relating to the state-by-state differences in Medicaid coverage, but we are looking at utilization patterns of poor people who are likely to be eligible for Medicaid and of the elderly veteran population.

Question 20. I am aware that VA report to the Chief Medical Director concerning ambulatory care will be completed sometime in July. I would ask that the VA please provide a copy of this report to the Committee at that time.

Answer 20. The report in question addresses resource allocation. One facet of that report involves ambulatory care. We will be happy to provide a copy of the final report.

Question 21. What are your views on providing those with the most limited eligibility greater access to inpatient rather than outpatient care? What would happen if that eligibility were to be reversed?

Answer 21. Providing greater access to inpatient care for those veterans with the most limited eligibility is not a cost-effective method of reducing the outpatient workload. The legislation authorizing ambulatory care in 1973 was considered necessary for promoting efficiency and economy in operations. The intent was to authorize outpatient care to obviate the need for the more expensive alternative, inpatient care. In most situations, the medical needs of veterans can most appropriately be satisfied in an outpatient setting, thus eliminating the need for more expensive hospitalization. Greater access to inpatient care would be less cost-effective, especially when it is possible to obviate such costly inpatient care by providing the required care in an outpatient environment.

Question 22. What specific cost-containment mechanisms are used in planning for current and future outpatient needs?

Answer 22. The VA operates both its inpatient and outpatient programs under the same set of rigorous cost-containments controls. These controls begin with the prospectively-determined budget under which the Agency operates. The Agency cost containment program, in utilizing a "prospective budget," has a "cap" or ceiling on budget expenditures which is distinct from a "cap" on revenues or income. The budget preparation is built from the first level of requests from all VA health care facilities based on the requirement to meet anticipated or planned workload and other mission needs. This is followed by multiple and stringent review processes to establish the functions and priorities within this budgetary limitation which is "prospectively determined." VA management, therefore, operates with a national budget which is established prior to rendering of medical care and is distributed to each facility prior to the budget implemental year.

Essential elements available to the VA for the annual budget preparation include a historical and projected data base, performance and productivity indicators, standards for quality of care, patient satisfaction information, space and functional indexes for capital maintenance and improvements, and equipment life tables. This budget process requires skillful management which makes use of incentives, controls, and constraints that are different than those used by most health delivery systems operating under a

fiscal method of "cash flow" and cost reimbursement. VA cost containment requires "cost savings" and does not permit "cost shifting" to meet priorities and management by objectives.

The process of budget formulation for VA health care facilities is initiated through the MEDIPP process, by the individual hospital and clinic unit and is then aggregated to the consortium level of health care facilities comprising the VA medical district. These medical district budget formulations are based upon realistic resource and personnel requests of known or planned workload trends, local and national priorities, specific guidelines of constraint, prior fiscal years' statistics, and experiences and continuous program evaluations. At the national level, the Department budget consolidates these separate medical district submissions and performs detailed and extensive administrative review. The Department of Medicine and Surgery then participates in an Agency-wide review prior to budget submission to the Office of Management and Budget where further careful review occurs before becoming part of the President's Annual Budget Request.

Congressional Oversight Committees for Veterans Affairs and the Congressional Appropriation Committees perform a further in-depth review and justification process prior to recommending final approval to the Congress of this "prospective budget" as an appropriation for the Department. A pattern of multiple reductions at every stringent review step occurs, adding significantly to the

process of strong cost containment. The VA budgetary formulation process does not automatically permit management flexibility to increase the budget in order to cover inflationary costs which include increased fuel and utility rates, energy utilization, cost of drugs and supplies, wage rates, and cost to purchase services. Past experience indicates that these "uncontrollable costs" are usually fully reflected in the justification of a supplemental appropriation process. Management must, therefore, control episodes of care costs, per diem cost, and workload volume through the establishment of priorities for care and careful monitoring and evaluation of the care process without assurances in advance that "uncontrollable" costs will receive supplemental funding.

RESPONSE OF THE VETERANS' ADMINISTRATION TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN CRANSTON, RANKING MINORITY MEMBER OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1A. What guidance does Central Office provide to field facilities regarding determinations of eligibility for outpatient care and for implementing the priorities established for providing such care?

Answer 1A. Guidance is provided to field facilities by Central Office through the Department of Medicine and Surgery's Manual M-1, Part I, Chapter 17, "Outpatient Care - Staff", and VA Regulation 6060 and 6060.7. The Department of Medicine and Surgery's manual is kept current by the issuance of manual changes and/or interim issues, when necessary, to keep the field facilities advised of procedural changes. The Department of Medicine and Surgery is in the process of preparing a complete revision of Chapter 17 of the manual, as well as revising VA regulations as a result of the enactment of recent legislation.

Question 1B. Please provide copies of all current written guidance in this area.

Answer 1B. Attached are copies of the Department of Medicine and Surgery Manual M-1, Part I, Chapter 17 and relevant interim issues. Also provided are copies of VA Regulation 6060 and 6060.7.

Veterans Administration
Department of Medicine and Surgery
Washington, D.C. 20420

M-1, Part I
Chapter 17

December 21, 1970

Chapter 17, "Outpatient Care–Staff," Part I, "Medical Administration Activities," VA Department of Medicine and Surgery Manual M-1, "Operations," is revised as indicated below:

NOTE 1: Beginning with this revision, chapter 17 will be published with its own series of changes and will carry an RPC number separate and distinct from other chapters of M-1, part I.

NOTE 2: The purpose of this change, other than editorial, is to:

a. Centralize policies, procedures, and references, by section, according to veteran's entitlement to outpatient care.

b. Provide a new section on service-connected outpatient treatment.

c. Provide a new section on aid and attendance outpatient treatment.

d. Provide a new section on nonbed care.

e. Substitute the abbreviation "NBC" for "TV."

f. Substitute the abbreviation "OPT-NSC" for "PHC."

g. Provide that equipment, furnishings and decorating materials in areas and offices frequented by patients and the general public periodically will be updated.

h. Provide that a centralized scheduling system will be used to make all appointments and to control outpatient examination and treatment activities.

i. Provide that daily appointment plans will be subdivided into appropriate time intervals, and that the full resources of the professional staff will be utilized.

j. Provide for the use of VA Form 07-3542c, Notice to Report.

k. Provide that VA Form 572, Request for Change of Address, will be completed if the veteran is in receipt of monetary benefits.

l. Provide that all necessary resources of the VA will be used to the fullest extent in preventive care measures.

m. Provide that OPT-SC will be used for prehospital workup.

n. Eliminate the requirement that VA Form 10-2827 be prepared when outpatient treatment has been recommended for a service-connected disability following a period of hospitalization.

o. Provide that a patient will not be placed in the PBC program for education and training purposes.

p. Provide that a medical records folder will be prepared for each person placed in the PBC program.

q. Provide that the PBC usually will be provided by the hospital inpatient staff.

r. Provide that patients will be released from inpatient care rather than discharged.

s. Provide for the furnishing of outpatient medical service for a veteran of any war who has a total disability, permanent in nature, resulting from a service-connected disability.

NOTE: Current pages only are included in this reprint.

t. Provide that patients in an OPT-NSC status generally will be furnished treatment at the appropriate VA station nearest the patient's home.

u. Provide that patients being treated on OPT-NSC may participate in education and training program, if incidental to treatment to which the patient is entitled.

v. Provide that the Tumor Board will review and approve all terminations of OPT-NSC tumor care.

w. Provide that VA Form 10-1000a may be used if bed occupancy does not exceed 48 hours.

x. Provide that patients readmitted to the hospital while on OPT-NSC will be carefully evaluated before release from current inpatient status to determine if OPT-NSC is still required.

y. Provide that records may be corrected to permit OPT-NSC where release was made in error.

z. Provide that treatment may be authorized on a fee basis for veterans eligible for OPT-A&A, when essential services are not available at an appropriate VA station.

aa. Provide that veterans in receipt of aid and attendance, pension, compensation or allowance, or by reason of being permanently housebound, may be furnished medical (not dental) care for any condition.

Pages 17-i through 17-iii, 17-1 through 17-9 and 17A-1 through 17A-5: Remove these pages and substitute pages 17-i through 17-iii, 17-1 through 17-9 and 17A-1 through 17A-5 attached.

M.J. MUSSER, M.D.
Chief Medical Director

Distribution: RPC: 1108 assigned
FD This ID same as RPC: 1016

RESCISSIONS

The following material is rescinded:

1. COMPLETE RESCISSIONS

a. Manuals

Changes 111, 137, 145, 156, M-1, part I

b. Circulars - 10-73-25, 10-74-13, 10-74-245, 10-76-181

c. Interim Issues 10-76-21, 10-76-38, 10-76-1, 10-76-4, 10-80-41

CHAPTER 17. OUTPATIENT CARE STAFF

SECTION I. SCHEDULING, RECEPTION AND ROUTING

17.01 SCHEDULING

a. A centralized scheduling system will be used to make all appointments and to control all outpatient examinations, treatments and/or services that are rendered on an appointment basis. The centralized Scheduling activity will be located at one control point and, whenever space, workload and layout permit, will be combined with reception, routing and beneficiary travel functions.

b. The Scheduling activity will be furnished timely and adequate information about scheduling capabilities, absences, conferences, special clinics, etc. Standard time allocations, based on average requirements at the station, will be established for each type of examination, treatment and/or service. Standard time allocations and changes thereto will be approved by the Chief of Staff. Periodic studies will be made to determine the need for changes. When it is known in advance in the case of an individual patient that the time required will be less or more than that which is provided by the standard allocation, the Scheduling activity will be notified to make necessary changes.

c. The Scheduling activity will schedule examinations, treatments and/or services to insure that, insofar as possible, the patient will receive all pending services during one visit.

d. The Scheduling activity will schedule more patients to report than normally could be accepted by the available staff. The degree of overscheduling will be consistent with past experiences as to the number of patients normally failing to report. Periodic studies will be made to determine the need for changes in overscheduling. The amount of overscheduling will be approved by the Chief of Staff.

17.02 APPOINTMENTS

a. A daily appointment plan will be prepared, utilizing the full resources of physicians, dentists and others (full time, part time, consultant, attendings, etc.) and for appropriate ancillary services. The appointment plan will be subdivided into appropriate time intervals throughout the total workday.

b. All outpatients will be given advance appointments whenever possible. All appointments will be made by the centralized Scheduling activity. Recommendations for recall of patients should normally be couched in a general time frame, i.e., "recall in approximately 1 month." Requests by the staff for appointments at a specific time and date should be avoided but will be made when it is professionally justified. Proposed recall appointments will be discussed with the patient if he is present in the clinic. The date and time selected should be agreeable with the patient, if possible.

c. Appointments will be recorded on VA Form 7051 or other appropriate medium. Completed schedules will be disposed of in accordance with DM&S Records Control Schedule 10-1.

17.03 RECEPTION

a. Reception areas are normally the first places the veteran and the general public makes contact with the VA. These areas should not only be functional but esthetically pleasing. Reception areas must be easily accessible to patients who arrive either by private or public transportation. The areas will be in prime space, preferably on the ground floor and in the building a patient would logically enter as he approaches the hospital or clinic. Reception areas will be made physically comfortable, with particular attention given to cleanliness, attractive and comfortable furniture, temperature and ventilation control, seating arrangements, restroom and coatroom facilities, paintings or pictures, plants, lighting, draperies, magazines, public telephones, music, etc. Reception areas and all other areas and offices frequented by patients and the general public will be periodically updated

with modern equipment, furnishings, and decorating materials. Prescribed posters regarding veterans' medical benefits will be prominently displayed. If notices must be posted on walls they will be kept to a minimum, and signs restrictive or prohibitive in nature will be avoided. Reception areas should be located to facilitate flow to and from physicians, clinics, services, and offices. The Hospital or Clinic Director is responsible for assigning space for reception functions which will most adequately meet these criteria. In exercising this responsibility he shall be guided by the principle that patient reception and care are primary considerations and that the location of all other administrative offices not directly concerned with reception activities is of secondary importance.

b. The Reception activity is responsible for receiving, interviewing and routing all persons who report for outpatient treatment or examination, and the clerical processing and preparation thereto. This includes initiation of the required forms prior to referral to professional services. Precautions will be taken to prevent spread of infection when individuals with contagious diseases report to the clinic. It is important that applicants and others receive prompt, courteous and helpful assistance. Careful questioning will assure prompt and correct referrals. Giving complete information, furnishing clear, concise instructions and reducing waiting time to a minimum will expedite patient flow, reduce clinic congestion and help maintain favorable public impressions of the VA medical program.

c. An applicant will not be expected to furnish information of a personal or confidential nature in public, therefore, privacy to the extent necessary to accomplish this objective will be maintained. Although records must be readily available to both administrative and professional personnel, appropriate measures will be taken to insure they are not accessible to the applicant or other unauthorized personnel.

d. When the veteran indicates he has a different address from that shown on VA records, VA Form 572, Request for Change of Address, will be completed and forwarded to the appropriate regional office if the veteran is in receipt of monetary benefits. A notation of the change will be made in all station active medical records.

17.04 ROUTING

Prepare VA Form 10-2875, Outpatient Routing List, in accordance with instructions in appendix 17A. Routing will be closely coordinated with the local appointment system so that waiting time will be minimized and the time of clinic staff used effectively. Escort service will be provided when necessary.

17.05-17.06 (Reserved.)

SECTION II. OUTPATIENT TREATMENT-SERVICE CONNECTED (OPT-SC)

17.07 GENERAL

a. VA Regulations 6060 (A), (B), and (G) and 6123 authorize the furnishing of medical and dental services for SC (service-connected) disabilities or conditions adjunct thereto. For the purposes of this section, any disability of a Spanish-American War veteran is considered SC. (See VA Regulation 6060(D).)

"b. VA Regulation 6060(H) authorizes the furnishing of medical services for NSC (non-service-connected) conditions of veterans adjudicated as having service-connected disabilities rated 50 percent or more. Outpatient dental care can be provided if adjunct to a service-connected condition or for an NSC condition when such treatment was started during a period of inpatient care and had been professionally determined to be necessary to continue following discharge."

17.08 POLICY

a. OPT (outpatient treatment) for SC conditions will be provided to the fullest extent for the usual curative and maintenance purposes. In addition, care will be afforded to preclude or limit regression and/or the need for hospitalization. All necessary resources of the VA medical program will be used in this objective.

b. Treatment will be furnished, to the extent practicable, on a staff basis at the VA station with appropriate facilities nearest the patient's home. Treatment may be furnished on a fee basis, however, when the needed services cannot be provided by VA facilities, or when other circumstances such as health of the patient, or distances to be traveled give sufficient justification. Basic to the decision in each case is a determination as to which procedure is in the best interest of the veteran and the VA.

c. Any treatment and/or examination that is professionally indicated in the preparation of a veteran requesting hospitalization for an SC condition will be accomplished on an OP-SC basis.

17.09 PROCEDURES

a. Applicants will be assisted by reception personnel, if necessary, in completing the application for OPT. Every effort will be made to obtain complete information so that establishment of eligibility and subsequent authorization will be expedited. If action can be taken without delay on an application for treatment, eligibility will be determined, appropriate records completed and required care authorized. Additional instructions for processing applications and determining eligibility are in chapter 16 for medical care and in chapter 19 for dental care. In no instance will an applicant be dismissed without being referred to a physician.

b. Preparation of a formal application for OPT is not necessary when treatment has been recommended following a period of hospitalization. VA Form 10-1000, Hospital Summary, will include recommended treatment. When the treatment is to be performed at another VA station, the Chief of Medical Administration of the releasing hospital will forward the medical record to the receiving station with the recommendation for followup OPT. The veteran will be notified by the releasing hospital of action taken.

17.10-17.12 (Reserved.)

SECTION III. OUTPATIENT TREATMENT-PRE-BED CARE (OPT-PBC)

17.13 GENERAL

Certain NSC veterans may be furnished prehospital outpatient services under the authority of VA Regulation 6060(F). The objective is to permit the VA to use hospital beds more effectively by reducing length of stay and thus increasing turnover. Under this program there may be a complete workup on an outpatient basis in preparation for hospitalization in a manner similar to private practice. Preparatory medical care must be completed in a relatively short period prior to admission if it is to be of clinical value for the scheduled hospitalization.

17.14 POLICY

"a. When an applicant is not admitted to bed care, scheduled for admission within 15 calendar days, placed on the waiting list, or rejected for care on the date of the initial VA examination, doubt as to action to be taken will be resolved in favor of admission and the patient placed in the PBC (pre-bed care) program." Chgd. by II 10-71-31

b.

c. Veterans scheduled for admission from the waiting list may be placed in the PBC program in preparation for admission within the same time limit specified in subparagraph a(3) above.

d. Patients in a PBC status may receive examination and treatment (including medications and supplies) to prepare them for the scheduled episode of hospital care. Dental prostheses, wheelchairs, artificial limbs, trusses and similar appliances, and clothing may not be furnished prior to admission.

e. Generally, the admitting hospital inpatient staff will provide PBC. By agreement between the respective Directors, another VA hospital or clinic may provide PBC when the best interests of the veteran and the VA will be served. Necessary records will be forwarded to the assisting hospital or clinic. When PBC is completed, all records will be returned to the admitting hospital. Essential services not available at an appropriate VA station may be authorized on a fee basis.

f. A patient will not be placed or retained in the PBC program for education and training purposes.

g. A veteran who is entitled to outpatient care under the VA Regulations 6060 (A) through (D), 6060 (G) through (I) and 6123 will not be placed in this program. Any pre-hospital workup will be authorized in accordance with section II, and usually will be provided by the inpatient staff. This does not preclude care of an NSC condition on an OPT-PBC basis for these veterans.

The Chief, Outpatient Service, will have primary responsibility for placement of applicants in the PBC program. Consultation assistance will be provided as necessary by appropriate members of the staff.

17.15 PROCEDURES

a. An applicant placed in the PBC program will have the intent of the program explained to him. (It is not necessary to specify the exact date of admission at this time, but adequate controls will be maintained to insure adherence to the established time limits.) Appointments will be scheduled for additional prescribed procedures so that diagnostic data will not be outdated at time of admission.

b. Prominently stamp "PBC" on the application for hospital care and prepare VA Form 10-2580, Locator Card, initiate a medical records folder to hold PBC records and prepare a four-line plate (if used locally) containing name, identification number, claim number, date of birth and "PBC." Use SF 509, Doctor's Progress Notes, to record clinical findings and comments made subsequent to the initial examination. Completed PBC reports will be forwarded to the Reception activity for professional review and necessary action. File these reports with the patient's other PBC records.

c. For admission from PBC, prepare the admission plate or stencil and follow routine admission procedures. Source of admission will be "PBC." The application and related administrative records will be filed in the patient's administrative records folder. The medical certificate of the application and other PBC medical records will be filed in the VA medical records folder.

d. Scheduled admission from PBC status will be canceled when hospital care is not necessary.

17.16 STATISTICAL REPORTING

a. A heading entitled "ADMISSIONS FROM PBC STATUS" will be inserted under "GAINS" on the gains and losses sheet. (It should be noted that a veteran in PBC status is an outpatient and is not an inpatient until he becomes a bed occupant.)

b. In order that statistics may be accumulated for reporting purposes, a separate section of the gains and losses sheet may be created immediately following the bed census report and entitled "PBC Report." This may be used to record the activity of patients, by name, in PBC status under the appropriate heading of "GAINS" or "LOSSES." A recapitulation may also be given, as required for local management purposes, showing such information as (1) number remaining from previous report; (2) gains; (3) admitted as scheduled; (4) other losses, specifying reasons; (5) number remaining this report; or (6) number of PBC visits this date.

17.17-17.18 (Reserved.)

SECTION IV. OUTPATIENT TREATMENT-NON-SERVICE-CONNECTED (OPT-NSC)

17.19 GENERAL

Certain NSC veterans may be furnished outpatient care that is reasonably necessary to complete an episode of VA authorized inpatient care. The authority is VA Regulation 6060(F). Beneficiaries of other Federal agencies may also be provided OPT-NSC when necessary incident to a period of authorized inpatient care. The authority is VA Regulation 6060.1.

17.20 POLICY

a. OPT-NSC will be planned to facilitate early release and to assure optimum results from the episode of hospitalization. When hospital care has progressed to the point where it is reasonable to anticipate that treatment for the condition for which hospitalization was required may be concluded satisfactorily on an outpatient basis, the patient will be released from inpatient care and an appointment arranged for the initial visit. Not all patients released from inpatient care will require outpatient care.

b. This program which provides medical benefits for the NSC veteran requiring outpatient care as a part of a period of hospitalization will be administered in such a way as to encourage patients to return to their family physicians for continuation of treatment at no expense to the VA.

c. Patients will not be admitted to hospitals for the purpose of placing them in the OPT program except those patients admitted for the purpose of placing them in the Day Hospital Program.

d. A patient in OPT status will [ ] be furnished treatment at the appropriate VA station nearest his home. In no event, however, will a patient be referred for OPT at another station without [ ] advance agreement. If an agreement cannot be reached, OPT will be provided at the place of hospitalization [and the appropriate Regional Medical Director will be advised and furnished copies of appropriate documents and correspondence.] Veterans receiving hospital care at VA expense in other Federal hospitals may return to those facilities for OPT, or to another VA station with advance agreement. A patient referred for followup care at another station will not be released from OPT status by the receiving station without reexamination, except when release is indicated because he fails to keep scheduled appointments. OPT may be authorized on a fee basis for essential services not available at an appropriate VA station.

e. Patients remaining in the OPT program will be examined at least semiannually to evaluate the regimen of care and to determine the need for further treatment. This is not mandatory for tuberculosis and tumor cases.

Chgd. by
I1 10-77-51

f. OPT-NSC Care may be provided for a period not in excess of twelve months after discharge from inpatient care except where the Administrator finds a longer period is required by virtue of the disability being treated. In any event, entitlement will cease and treatment will be terminated when (1) it is professionally determined that the condition for which hospital care was provided has become stable or (2) there is no longer a close relationship to the preceding episode of hospitalization. The number of visits should be consistent with good medical practices.

g. Veterans who are entitled to continued care under the provisions of VA Regulations 6060 (A) through (D), 6060 (G) through (I), and 6123 will not be placed in the OPT-NSC program for care of those conditions.

This will not preclude treatment of an NSC condition on an OPT-NSC basis for these veterans. Veterans eligible for care under authority of VA Regulations 6060 (A) through (D), 6060 (G) and (H) and 6123 will be provided care in accordance with section II. Veterans eligible for care under authority of VA Regulation 6060 (I) will be provided care in accordance with section V.

h. Medical need and eligibility will be established by the releasing hospital. Records transferred to another hospital or clinic will be clearly documented to reflect the veteran's need for and entitlement to care in this program. The receiving station will assume responsibility for determining when treatment incident to hospital care should be terminated under the provisions of subparagraph f above.

i. Outpatient treatment of patients placed in the OPT program will be limited to the conditions for which hospitalization was furnished. The patient will be furnished required examination, treatment, medication and supplies. The patient will be supplied sufficient amounts of medication to maintain the prescribed regimen of care until he reports for his first followup visit. Thereafter, medication will be provided as prescribed by the responsible treating physician.

j. Dental and prosthetic appliances, sensory aids, and/or medical equipment and supplies and therapeutic and rehabilitation devices may be loaned or issued to patients as a part of authorized OPT. A medical or dental determination is required in each instance that the issuance or loan of such appliances, aids or accessories is reasonable and necessary for completing the medical or dental treatment of the condition for which the patient was hospitalized.

k. A patient will not be placed on OPT-NSC status solely for education or training purposes, nor will he be retained on the rolls solely for either or both of these purposes. There is no objection to participation by OPT-NSC patients in education or training programs if this is accomplished incidental to needed treatment.

l. The Chief of Medical Administration will be responsible for establishing a control system which will account for every patient remaining in an OPT status.

17.21 PROCEDURES

a. The release procedures for patients being placed in OPT program are the same as those prescribed for a regular discharge. VA Form 10-1000, Hospital Summary, will include instructions given to the patient and approximate date of first visit. If the patient is referred elsewhere, recommended followup care will be prescribed and other appropriate action taken.

b. When a patient is to receive OPT at the hospital from which he is discharged, he will be referred to the Reception activity or other control point for discharge processing and scheduling. (If patient is discharged in error and not scheduled for needed OPT-NSC, action will be taken to correct records to permit OPT-NSC.) He will be furnished appointment information, indicating the followup date, prior to departure from the hospital. If followup care is to be provided by another VA station, arrangements for referral of the patient normally will be made prior to the patient's departure.

c. If a patient in the OPT program fails to keep a scheduled appointment, a reasonable opportunity to report will be afforded. If a second appointment is broken without an acceptable reason, OPT status will be terminated and the treatment record marked "Failed to report (date)." Before treatment is terminated, the patient's medical record will be referred to the physician responsible for his care for review and approval of action to be taken. In addition, the records of any patient being followed for tumor will be referred to the Tumor Board for review and approval.

d. When it is necessary to rehospitalize a patient for the same condition for which he is currently receiving OPT, completion of an application for hospitalization is not required. This readmission requires only such additional administrative admission records as are necessary. If fewer than 30 days have elapsed since last

discharge, complete routine workup need not be repeated. Significant changes will be recorded on the appropriate medical record forms. VA Form 10-1000a, Abbreviated Medical Record, may be used if bed occupancy does not exceed 48 hours. "Source of Admission" will be OPT-NSC.

e. A patient on followup care (OPT-NSC), who is readmitted for the same or another condition, will be carefully evaluated before release from current inpatient status to determine if OPT-NSC is still required. When, through an error, release is made resulting in termination of needed posthospital care, action will be taken to correct records to permit continued OPT.

17.22 RECORDS

a. The VA medical records already established will be used for appropriate entries during OPT status. When followup care is completed, the patient's physician will make an appropriate entry, including the termination date of OPT, on SF 509, Doctor's Progress Notes.

b. When followup care is to be provided by another VA station, the medical records and administrative folders will be transferred. The completed VA medical records and administrative folders will be retained by the receiving hospital or clinic.

17.23 OTHER FEDERAL HOSPITALS

a. **General.** The general concepts of the OPT-NSC program are applicable to patients who receive authorized care in other Federal hospitals. OPT will normally be provided such patients at the Federal hospital which provided inpatient care, however, consideration will be given to furnishing OPT at the VA hospital or clinic nearest the veteran's home when it would be in the best interests of both the patient and Government. Agreements have been concluded with the Army, Navy and Air Force, and the Department of Health, Education, and Welfare for the provision of OPT to shorten the period of inpatient stay for eligible veterans who receive authorized care in hospitals, where bed allocations have been granted. The Navy agreement provides that the decision to participate in the program will be made at the local level by the individual Commanding Officer on request by the VA Hospital or Clinic Director.

b. **Authorization Procedure.** See chapter 21.

c. **Program Controls.** Hospital and Clinic Directors will observe the policies in paragraphs 17.20 and 17.21. Close coordination will be established with heads of other Federal hospitals to assure a complete understanding of this program, including mechanics of its operation and necessity for providing information promptly on patients requiring OPT.

17.24 OPT-NSC FOR WOMEN VETERANS HOSPITALIZED IN PRIVATE, STATE OR MUNICIPAL FACILITIES

The general concepts of the OPT-NSC program apply to women veterans receiving VA authorized hospital care for NSC conditions in private, State or municipal hospitals. OPT will be provided at the nearest appropriate VA station. If VA facilities are not feasibly available, or when other circumstances such as health of the patient, or distances to be traveled give sufficient justification, OPT may be furnished on a fee basis. The authorizing clinic will make the initial determination of medical eligibility and arrangements for furnishing followup care. The VA station providing followup care will determine when it will be terminated.

17.25-17.26 (Reserved.)

SECTION V OUTPATIENT TREATMENT-AID AND ATTENDANCE AND HOUSEBOUND

17.27 GENERAL

VA Regulation 6060(1) authorizes the furnishing of medical services for certain NSC conditions.

Chgd. by IT 10-81-63

17.28 POLICY "a. Any veteran of the Mexican Border Period, World War I, or in receipt of increased pension or additional compensation or allowance based on the need of regular aid and attendance or by reason of being permanently housebound, or who, but for receipt of retired pay would be in receipt of such pension, compensation or allowance may be furnished such medical services as are reasonably necessary for any disability. (Dental care is not included unless such treatment was started during a period of inpatient care.)

b. OPT may be authorized on a fee basis subject to the criteria in paragraph 17.08b.

17.29 PROCEDURES

Veterans entitled to OPT will be notified of their eligibility from a central mailing point. When the veteran signs the notice of eligibility and submits it to the VA, such notice will constitute an application for outpatient care.

17.30-17.31 (Reserved.)

SECTION VI. NONBED CARE (NBC)

17.32 POLICY

a. Patients, under commitment and/or for whom the station is receiving an institutional award, may be furnished NBC (nonbed care) when inpatient care has progressed to a point where it is reasonable to anticipate that treatment may be concluded satisfactorily on a nonbed status.

b. Not all such patients released from inpatient care for continued care on a nonbed status will require NBC. State laws permitting and/or when no financial difficulties will be experienced, patients requiring continued treatment to complete hospitalization will be cared for on OPT-NSC. (See sec. IV.)

c. Patients placed in a NBC status generally will be furnished treatment, medications and supplies by the appropriate VA station nearest his home. In no event, however, will a patient be referred to another station without mutual advance agreement. If agreement is reached for complete responsibility for followup care by another station, records, and funds if any, will be transferred in accordance with current instructions. If an agreement cannot be reached, NBC will be provided by the place of inpatient care. NBC may be authorized on a fee basis for essential services not available at an appropriate VA station.

d. Patients in an NBC status will be examined at least semiannually to evaluate the regimen of care and to determine the need for further treatment. The VA medical records already established will be used for appropriate entries during NBC status.

e. There is no limitation on the length of time a patient will be carried in an NBC status. However, entitlement will cease and treatment will be terminated when the commitment and/or the institutional award has been discontinued and it has been professionally determined that the condition for which inpatient care was provided has become stable or there is no longer a close relationship to the preceding episode of inpatient care.

17.33-17.34 (Reserved.)

SECTION VII. RESEARCH

17.35 POLICY

a. In some instances it may be desirable for patients to be studied for research purposes. Without exception, such studies must be integral funded components of a research project previously processed and approved by the Hospital Research Committee and by the Hospital Director.

b. When a patient is assigned to OPT-NSC in order to complete treatment for the condition for which hospitalization was required, he also may be involved in a research study. Under such circumstances there will be no attempt to prorate costs to medical research funds.

c. When OPT is terminated under the provisions of paragraph 17.20f, but there is need for research followup, the provisions of subparagraph d below are applicable.

d. When a patient is assigned solely for research purposes or makes a visit solely for research purposes, medical research funds will be used to pay beneficiary travel costs. Also, the cost of drugs, supplies, and contractual services purchased exclusively for the research project will be charged to medical research funds.

e. Whenever medical research funds will be expended for posthospital research studies, prior approval of the project and expenditures must be obtained from the Director, Research Service.

f. The Chief of Medical Administration will be responsible for establishing procedures and controls to properly account for all patients who report to the hospital for this purpose.

17.36-17.37 (Reserved.)

SECTION IX. PRIORITIES FOR OUTPATIENT CARE AND SERVICES

17.50 GENERAL

The enrollment and continuing care of eligible patients in an outpatient status will be effectively managed according to priorities established in this section.

17.51 POLICY

a. Those persons requiring immediate attention will be provided emergency care without regard to priorities.

b. Enrollment in, or care following enrollment in an outpatient program will be based on a professional determination of the need for care, and the applicant or patient will be scheduled and/or seen according to the following priorities and in the sequence indicated within these priorities.

c. Priorities I a, b and c, and priority II are mandated by 38 U.S.C. 612(i). Priorities III through VI are established by departmental policy.

PRIORITY I

a. Veterans requiring care for service-connected disabilities or for disabilities incurred in line of duty for which they were released or retired from the active military, naval or air service. (This category also includes Spanish-American War veterans requiring care for any disability.)

b. Veterans with a service-connected disability or disabilities rated at 50 percent or more.

c. Veterans with service-connected disabilities or retired for disabilities incurred in line of duty, requiring care for non-service-connected disabilities [(including any veteran requiring examination to determine the existence or rating of a service-connected disability).

(NOTE: Veterans entitled to vocational rehabilitation training, who are receiving or in need of such training, and medical services are determined necessary for any of the reasons given in VA Regulation 6036(B), are categorized in either priority I (a), (b) or (c), as appropriate.)]

PRIORITY II

a. Veterans who are former prisoners of war.

b. Veterans who are receiving care for conditions possibly related to exposure to Agent Orange, other hazardous substances or ionizing radiation."

Chgd. by II 10-81-48

allowance."

PRIORITY III

Chgd. by II 10-81-63

"Veterans of the Mexican Border Period, World War I, or veterans in receipt of increased pension or special allowance based on the need of regular aid and attendance or by reason of being permanently housebound or who, but for receipt of retired pay, would be in receipt of such increased pension or special allowance."

PRIORITY IV

[Beneficiaries receiving authorized examinations for VA pension, dependency and indemnity compensation or examinations for insurance purposes.]

PRIORITY V

a. Non-service-connected veterans requiring post-hospital care (OPT-NSC).

b. Non-service-connected veterans requiring PBC (pre-bed care).

PRIORITY VI

a. Non-service-connected veterans requiring care to obviate the need for hospitalization.

b. Former members of the armed forces retired from the service on the basis of length of service who are to be provided outpatient care as beneficiaries of the armed forces.

PRIORITY VII

a. Persons treated under sharing agreements.

b. Beneficiaries from other Federal agencies, except as described in priority Vb.

c. Veterans of nations allied with the United States in World War I or II receiving medical care under the authority of 38 U.S.C. 109(a).

17.52 BASIC GUIDELINES

a. Scheduling activities will be conducted in strict compliance with the provisions of section I to provide an efficient and effective scheduling system. Special care will be exercised to assure maximum use of available appointment periods, personnel and [facilities] while continuing to meet the needs of unscheduled emergent or high priority applicants.

b. When the demand for care is consistently greater than the care which can be provided with available VA resources, restrictions on accepting new applicants will be imposed by the health care facility Director. In such event, admission of applicants to outpatient programs will be restricted by not accepting applicants from priority categories below the priority level where appropriate care can be provided within available resources. These restrictions may be applied by clinical subspecialty or service. For example, if the Orthopedic Clinic is unable to provide timely appointments to patients, restrictions should be placed on accepting new applicants for outpatient orthopedic services from priority category VIc, then VIb, then VIa, then Vb, etc. Applicants who cannot be accepted for outpatient services will be referred to Social Work Service for review and counseling regarding the use of non-VA health care resources.

c. The responsibility and authority for the assignment of priorities for care is administrative. As such, the Chief of Medical Administration, or his/her administrative designee, will assure that appropriate priorities are assigned and, in collaboration with the relevant clinical service chiefs, that patients receive their care according to the assigned priority.

17.53 PROCEDURES

a. A patient appearing at the Reception activity seeking evaluation or treatment who does not have a scheduled appointment will be referred to triage or the general medicine clinic.

NOTE: Emergency cases, irrespective of priority status, will be referred for evaluation and appropriate care immediately.

b. If the person requesting evaluation without a scheduled appointment is appearing for the first time, the Reception activity will prepare a VA Form 10-10 containing only the individual's name and address, social security number, branch of military service, service-status and name and address of the next of kin, for referral with the person to triage. All available records of a person who had previously been hospitalized or enrolled in the outpatient program but who comes in for evaluation or treatment without a scheduled appointment will be obtained for referral with the individual to the evaluation team. Emergency cases will not be delayed for paperwork, or retrieval of records prior to referral to the evaluation team.

c. The triage or general medicine clinic will determine whether the nature of the illness presented by the patient:

(1) Is emergent, requiring immediate outpatient treatment.

SECTION X. DAY HOSPITAL PROGRAM

17.55 GENERAL

a. Selected psychiatric hospitals and general hospitals with psychiatric bed sections are authorized by VA Central Office to conduct a Day Hospital program.

b. DM&S Manual M-2, part X describes the Day Hospital program concept and related matters such as objectives of treatment, length of patient stay, treatment advantages, suggested staffing, and patient loads per unit.

c. Instructions for preparation and submission of Day Hospital program workload information for the Automated Management Information System are contained in VA Manual MP-6, part VI, supplement No. 1.2, chapter 39. Reports are submitted quarterly on AMIS segment 229, identified as RCS 10-282.

17.56 POLICY

The Day Hospital program is functionally an outpatient program in Psychiatry Service designed for patients needing a treatment regimen of a different intensity and utilizing a variety of treatment modalities than can be provided in other outpatient psychiatric programs. It is designed primarily to serve veterans who have experienced an emotional or situational crisis and need intensive treatment for the major portion of a day, several days a week, for a limited period of time, but do not need the bed, board and 24-hour supervision associated with full hospitalization.

17.57 RESPONSIBILITIES

a. The Chief, Psychiatry Service is responsible for overall management of the program, for developing and/or approving selection criteria for accepting candidates, and for monitoring and evaluating the effectiveness of the program.

b. The program director of the day hospital is responsible for determining the acceptability of patients for admission to the program according to defined admission criteria, and for having a member of the professional staff explain the treatment program to the patient to encourage complete cooperation.

c. Designees of the Chief, Medical Administration Service are responsible for determining legal eligibility of veterans for admission to the program and for administrative procedures relating to the preparation and processing of outpatient routing and statistical activity records for accumulating outpatient visit workload information.

17.58 PROCEDURES

a. **Admission to the Program**

(1) Eligibility for admission to the Day Hospital program is limited to persons eligible for outpatient treatment under VA Regulation 6060.

(2) No person will be placed in the program without approval of an authorized professional service member of the Day Hospital program staff.

(3) Inpatients committed by a court of competent jurisdiction will not be discharged to the Day Hospital program without documented approval by the Chief, Medical Administration Service who is responsible for coordinating such discharges with the District Counsel and the court.

(4) Inpatients for whom the Hospital Director is receiving an institutional award will not be discharged to the Day Hospital program without documented approval of the Chief, Medical Administration Service who is responsible for determining that the discharge to outpatient status and consequent termination of the institutional award will not result in financial hardship to the patient or to his or her dependents.

b. **Records**

(1) All reports and records relating to the day hospital episode of patient care will be filed in the CHR (consolidated health record) according to filing instructions in DM&S Manual M-1, part I, chapter 5.

(2) Eligibility for direct admission to the Day Hospital program will be documented on the current application for medical care, VA Form 10-10 or VA Form 10-10r, citing the appropriate subparagraph of VA Regulation 6060 as authority.

(3) Content of day hospital records and the frequency of progress note entries will be determined by the program director and approved by the Medical Record Committee. The discharge progress note or summary should contain established diagnoses for which medical care was given and the basic information suggested in part X of DM&S Manual M-2.

(4) Release of information to insurance companies concerning day hospital episodes of patient care will contain a prominent notification that, although the patient was not occupying a bed, he or she was under intensive day hospital care and definitive treatment for a specified number of hours a day for so many days a week. (Example: Six hours a day, 5 days a week.)

c. **Beneficiary Travel**

Payment or reimbursement for beneficiary travel will be based on individual eligibility and entitlement as prescribed in chapter 25.

d. **Submission of VA Form 10-7131, Exchange of Beneficiary Information and Request for Administrative and Adjudicative Action and VA Form 10-7132, Status Change**

(1) Notification is not required when a patient is admitted directly to a Day Hospital program.

(2) VA Form 10-7132, Status Change, will be sent to the VA regional office of jurisdiction when inpatients are discharged to the Day Hospital program, providing the VA Form 10-7132 had been requested. In addition to other information, the statement, "Discharged to Day Hospital" will be entered in "Remarks."

OUTPATIENT TREATMENT

6059 (§17.59). OUTPATIENT CARE FOR RESEARCH PURPOSES. Subject to the provisions of VA Regulation 6062(G), any person who is a bona fide volunteer may be furnished outpatient treatment when the treatment to be rendered is part of an approved VA research project and there are insufficient veteran-patients suitable for the project. (July 10, 1970)

6060 (§17.60). OUTPATIENT CARE FOR ELIGIBLE PERSONS. Medical services may be furnished [, within the limits of VA facilities,] to the following applicants under the conditions stated, except that applicants for dental treatment, as defined in subparagraphs (A) to (D) inclusive of this paragraph must also meet the applicable provisions of VA Regulation 6123: (Oct. 21, 1976)

(A) **For Service-Connected Disability.** Persons discharged or released from active military, naval, or air service, who are in need of treatment for a disease or injury adjudicated by the VA as incurred or aggravated in such service. (Oct. 1, 1967)

(B) **For Disability for Which Discharged.** Persons who were discharged or released under other than dishonorable conditions from active military, naval, or air service for disability incurred or aggravated in line of duty in active service who are in need of treatment for that condition which resulted in discharge or release for disability. A formal claim for disability compensation will not be required of an applicant eligible for outpatient treatment by reason of discharge or release for disability incurred or aggravated in line of duty; and a denial of a claim for disability compensation will not debar outpatient treatment for such disability. (Oct. 1, 1967)

(C) **For Veterans Entitled to Vocational Rehabilitation.** A veteran who has been found in need of training authorized under 38 U.S.C. ch. 31, and for whom an objective has been selected or who is pursuing vocational rehabilitation training is entitled to such medical services as are medically determined necessary for any of the reasons enumerated in VA Regulation 6036(B). A veteran in need of such training may also be furnished in a clinic operated by the VA any examination or immunization necessary to qualify him [or her] for admission to a training facility, except the Department of Medicine and Surgery may not authorize incidental transportation. (Apr. 25, 1967)

(D) **For Spanish-American War Veterans.** Persons who served in the active military, or naval service during the Spanish-American War, or Indian wars, when discharged from such service under other than dishonorable conditions who are in need of outpatient treatment. Such outpatient treatment will not include medical care and treatment necessary to and part of hospital care furnished a patient while in a hospital. (Oct. 1, 1967)

(E) **For Pre-Hospital Care.** Persons eligible for hospital care under VA Regulation 6047, where a professional determination is made that such care is reasonably necessary in preparation for admission of such persons [for care, or (to the extent that facilities are available)] to obviate the need for bed care. [(38 U.S.C. 612 (f) added PL 86-639 sec. 1; amended PL 93-82, sec. 103 (a); PL 94-581, sec. 103(a)(4)]. (Oct. 21, 1976)

(F) **For Post-Hospital Care.** Persons eligible for hospital care under VA Regulation 6047 who have been [furnished] hospital care, and outpatient [medical] care is reasonably necessary to complete treatment incident to such hospital care. [Said service may be provided not to exceed 12 months after discharge from the in-hospital treatment except where the attending physician finds that a longer period is required by virtue of the disability being treated. (38 U.S.C. 612(f); added PL 86-639, sec. 1; PL 93-82, sec. 103(a); PL 94-581, sec. 103(a)(5))] (Oct. 21, 1976)

99-946 O—82——6

(G) **For Adjunct Treatment.** Outpatient treatment may be authorized in accordance with prescribed principles for an adjunct non-service-connected condition associated with and held to be aggravating a disability from a disease or injury for which the veteran is entitled to receive outpatient care under this paragraph. The opinion of the Chief Medical Director may be requested in any individual case where advice is desired as to the propriety of furnishing adjunct treatment. (Oct. 1, 1967)

(H) **For Veterans [50] Percent or More Disabled From a Service-Connected Disability.** Outpatient care, except outpatient dental treatment, may be authorized to treat any non-service-connected disability of a veteran who has a service-connected disability rated at [50] percent or more. [(38 U.S.C. 612 as amended by PL 91-102; PL 98-82, sec. 103(a); PL 94-581, sec. 103)] (Oct. 21, 1976)

(I) **For Veterans Who Are Housebound or in Need of Aid and Attendance.** Any veteran who is in receipt of increased pension or additional compensation or allowance based on the need of regular aid and attendance or by reason of being permanently housebound, or who, but for the receipt of retired pay, would be in receipt of such pension, compensation or allowance. (38 U.S.C. 612(g)) (Oct. 22, 1970)

[(J) **Home Health Services.** Home health services determined by the VA to be necessary for effective and economical treatment of a disability may be furnished to any veteran to include home improvement and structural alterations as are necessary to assure the continuation of treatment or to provide access to the home or to essential lavatory and sanitary facilities.

(1) The cost to the VA or reimbursement by the VA to the veteran will not exceed $2,500 for home improvement or structural alterations to veterans being treated for a service-connected disability, and,

(2) Will not exceed $600 for veterans being treated for a non-service-connected disability and then only to veterans receiving authorized post-hospital care under the authority of VA Regulation 6060(F) or to veterans rated at 50 percent or more service connected. (38 U.S.C. 612(f); PL 93-82, sec. 101(c); PL 94-581, secs. 101(2), 103(7))] (Oct. 21, 1976)

6060.1 (§17.60a). OUTPATIENT CARE FOR MILITARY RETIREES AND OTHER BENEFICIARIES. Outpatient care for military retirees and other beneficiaries for which charges shall be made as required by VA Regulation 6062, may be authorized for persons properly referred by authorized officials of other Federal agencies for which the Administrator of Veterans Affairs may agree to render such service under the conditions stipulated by [the Administrator] and pensioners of nations allied with the United States in World War I and World War II when duly authorized. (Oct. 1, 1967)

6060.2 (§17.60b). OUTPATIENT CARE FOR VA EMPLOYEES AND OTHERS IN EMERGENCIES. Outpatient care for which charges shall be made as required by VA Regulation 6062, may be authorized for employees of the VA, their families, and the general public in emergencies, subject to conditions stipulated by the Administrator of Veterans Affairs. (Oct. 1, 1967)

6060.3 (§17.60c). SHARING SPECIALIZED MEDICAL RESOURCES ON AN OUTPATIENT BASIS. The use of a specialized medical resource or any medical service incidental to, and necessary for, its use under a sharing agreement entered into under VA Regulation 6210, may be authorized, on an outpatient basis if:

(A) In the case of a specialized medical resource and services made available by the other party to the sharing agreement, the patient is a veteran eligible under any provision of VA Regulation 6060, or (Oct. 1, 1967)

(B) In the case of a specialized medical resource and services available within the limits of VA facilities, the patient is a person designated by the other party to the sharing agreement as a patient to be benefited under the agreement. (Oct. 1, 1967)

6060.4 (§17.60d). PRESCRIPTIONS FILLED. Any prescription, which is not part of authorized VA hospital or outpatient care, for drugs and medicines ordered by a private or non-VA doctor of medicine or doctor of osteopathy duly licensed to practice in the jurisdiction where the prescription is written, shall be filled by a VA pharmacy, provided: (Aug. 31, 1967)

(A) The prescription is for a person who is receiving housebound benefits or who, based on the need for regular aid and attendance, is receiving additional compensation or allowance (wartime or peacetime) under 38 U.S.C. ch 11, or increased pension as a veteran of the Mexican border period, World War I, World War II, the Korean conflict, or the Vietnam era (or who is receiving a greater compensation benefit rather than such aid and attendance pension to which [the veteran] has been adjudicated to be presently eligible). An aid and attendance pensioner who is eligible for drugs and medicines under this paragraph whose pension has been discontinued because of excess income may continue to be provided with drugs and medicines even though his [or her] annual income exceeds the permissible income limitations, so long as it is no more than $500 above the maximum, and (Dec. 24, 1970)

(B) The drugs and medicines are prescribed as specific therapy in the treatment of any of the veteran's illnesses or injuries. (Aug. 31, 1967)

6060.5 (§17.60e). PRESCRIPTIONS IN ALASKA, AND TERRITORIES AND POSSESSIONS. In Alaska and territories and possessions, where there are no VA pharmacies, the expenses of any prescriptions filled by a private pharmacist which otherwise could have been filled by a VA pharmacy under VA Regulation 6060.4, may be reimbursed. (Aug. 31, 1967)

[6060.6 (§17.60f). MENTAL HEALTH SERVICES. Mental Health Services, as defined in VA Regulation 6030(L)(2), may be furnished the members of the immediate family, or legal guardian of the person or the individual in whose household such person certifies an intention to live, provided the person is eligible for care under provisions of VA Regulation 6047, 6054, or 6060 (A) (B) or (F). (38 USC 601(5), as amended by PL 93-82, sec. 101(b) and PL 94-581, sec. 102(1); 38 USC 601(6), as amended by PL 94-581, sec. 102(2); 38 USC 612, 613(b))] (Oct. 21, 1976)

[6060.7 (§17.60g). PRIORITIES FOR MEDICAL SERVICES. Unless compelling medical reasons indicate otherwise, eligible veterans shall be furnished outpatient medical services on a priority basis in the following order:

(A) to any veteran for a service-connected disability,

(B) to any veteran with a service-connected condition, rated at 50 percent or more,

(C) to any veteran with a disability rated as service connected,

(D) to any veteran eligible under the provisions of VA Regulation 6060(1). (38 U.S.C. 612(i); added PL 94-581, sec. 103(a)(8))] (Oct. 21, 1976)

VETERANS ADMINISTRATION
Department of Medicine and Surgery
Washington, D.C. 20420
December 23, 1981

Interim Issue 10-81-63

A. Basic Administrative Issue Affected: DM&S Manual M-1, Part I, Chapter 17

B. Other Issues Affected: II 10-80-5 and II 10-80-71

C. Reason for Issue: To advise all VA medical facilities that the authorization provided in II 10-80-5 for furnishing outpatient medical services for any disability to veterans of the Mexican Border Period or World War I remains in effect.

D. Text of Issue:

1. General

Authority for this change is contained among the various provisions of Public Law 96-151, Veterans Health Programs Extension and Improvement Act of 1979.

2. Specific

DM&S Manual M-1, Part I, Chapter 17 is changed as follows:

(a) Page 17-8, paragraph 17.28a is deleted and replaced by the following:

"a. Any veteran of the Mexican Border Period, World War I, or in receipt of increased pension or additional compensation or allowance based on the need of regular aid and attendance or by reason of being permanently housebound, or who, but for receipt of retired pay would be in receipt of such pension, compensation or allowance may be furnished such medical services as are reasonably necessary for any disability. (Dental care is not included unless such treatment was started during a period of inpatient care.)"

(b) Page 17-13, paragraph 17.51 is changed by amending "PRIORITY III" to read as follows:

"Veterans of the Mexican Border Period, World War I, or veterans in receipt of increased pension or special allowance based on the need of regular aid and attendance or by reason of being permanently housebound or who, but for receipt of retired pay, would be in receipt of such increased pension or special allowance."

II 10-81-63
December 23, 1981

E. RESCISSIONS: II 10-80-5 and II 10-80-71. This issue is rescinded on December 22, 1982.

DONALD L. CUSTIS, M.D.
Chief Medical Director

DISTRIBUTION: RPC: 1108
FD

625717

VETERANS ADMINISTRATION
Department of Medicine and Surgery
Washington, D.C. 20420
November 24, 1981

Interim Issue 10-81-52
(Confirmation Copy)

A. Basic Administrative Issue Affected: DM&S Manual M-1, Part I, Appendix 17A

B. Other Issues Affected: None

C. Reason for Issue: To advise field facilities to continue to prepare a VA Form 10-2875-1 or 10-2875-2, Outpatient Routing and Statistical Activity Record, for all dental outpatient visits and to repeat instructions provided in II 10-78-29.

D. Text of Issue: DM&S Manual M-1, Part I, Appendix 17A is changed as follows:

Paragraph 2b(4): Delete last sentence.

Paragraph 2b(5): Delete this paragraph and substitute the following:

"Outpatient Dental Visits: A VA Form 10-2875-1 or 10-2875-2, as appropriate, will be prepared for each outpatient visit made to a health care facility when the purpose of the visit is for dental services."

Paragraph 2b(6)(h): Delete this subparagraph.

E. Detailed Manual changes will be issued at a later date.

F. Rescission: This interim issue is rescinded on November 23, 1982.

DONALD L. CUSTIS, M.D.
Chief Medical Director

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VETERANS ADMINISTRATION
Department of Medicine and Surgery
Washington, D.C. 20420
October 6, 1981

INTERIM ISSUE 10-81-48
(Confirmation Copy)

A. Basic Administrative Issue Affected: DM&S Manual M-1, Part I, Chapter 17.

B. Other Issues Affected: None

C. Reason for Issue: To advise VA medical facilities of enactment of Public Law 97-37, Former Prisoners of War benefits Act of 1981, dated August 14, 1981, and to provide general instructions for implementing this new law.

D. Text of Issue:

1. General

a. P.L. 97-37 defines the term "former prisoner of war" to mean a person who while serving in the active military naval or air service was forcibly detained or interned in line of duty (1) by an enemy government or its agents or a hostile force during a period of war, or (2) by a foreign government or its agents or a hostile force during any other period under circumstances which the Administrator finds are comparable to forcible detention or internment during a period of war.

b. Former prisoners of war are eligible for hospital, and nursing home care without regard to the individual's age, service-connected status or the inability of such former prisoners of war to defray the expenses of such care.

c. Former prisoners of war are eligible under this legislation to receive outpatient treatment for any disability (except dental care) without regard to the individual's ability to defray the expenses of the care required. These individuals are not entitled to fee basis solely on their status as former POWs.

d. When claims of POW status cannot be confirmed by existing POW records or other documents, a request for confirmation will be submitted to the Adjudication Division.

2. Specific

This interim issue changes M-1, Part I, Chapter 17, Section IX. "PRIORITIES FOR OUTPATIENT CARE AND SERVICES", as follows: Existing Priority II is changed to Priority III and succeeding Priority Groups are to be changed accordingly. A new Priority II is established as "Veterans Who Are Former Prisoners of War".

II 10-81-48
October 6, 1981

E. The effective date for implementation of P.L. 97-37 is October 1, 1981.

F. RESCISSION: This issue is rescinded on October 5, 1982.

DONALD L. CUSTIS, M.D.
Chief Medical Director

DISTRIBUTION: RPC: 1108
FD

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VETERANS ADMINISTRATION
Department of Medicine and Surgery
Washington, D.C. 20420
May 14, 1981

INTERIM ISSUE 10-81-16

A. BASIC ADMINISTRATIVE ISSUE AFFECTED: DM&S Manual M-1, Part I, Chapter 17

B. OTHER ISSUES AFFECTED: II 10-79-16 and II 10-80-15

C. REASON FOR ISSUE: To direct that eligible veterans enrolled in the VA Outpatient Program receive all medical services, medications, supplies and benefits, as defined in Section 601(6), title 38, U.S.C.

D. TEXT OF ISSUE:

1. Veterans properly enrolled in an authorized outpatient program will be furnished required examinations, treatments, rehabilitative services, medications and supplies to which they are legally entitled, and which have been ordered by the responsible physician. Beneficiary travel will be provided when eligibility requirements therefore are met. Program controls as stated in VA procedures will be followed.

2. Health care facility Directors will maintain enrollments in outpatient programs at levels permitted within the limitations of available resources. This will be accomplished through the application of established priorities and procedures outlined in DM&S Manual M-1, Part I, Chapter 17, Section IX.

3. Applicants who cannot be accepted for outpatient services will be referred to Social Work Service for counseling regarding the use of non-VA health care resources. However, in instances where veterans in affected low priority groupings require services not available to them in the community, VA facilities will make a concerted effort to provide the necessary care.

E. RESCISSION: This issue is rescinded on May 14, 1981.

DONALD L. CUSTIS, M.D.
Chief Medical Director

DISTRIBUTION: RPC: 1108
FD

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TELEGRAPHIC MESSAGE

II 10-80-71
December 24, 1980

NAME OF AGENCY	PRECEDENCE	SECURITY CLASSIFICATION
VACO WASH.,DC 20420	ACTION: INFO.	
ACCOUNTING CLASSIFICATION	DATE PREPARED 12/12/80	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS
FOR INFORMATION CALL		
NAME ANTHONY RANCIATO (136F)	PHONE NUMBER 2851	

THIS SPACE FOR USE OF COMMUNICATION UNIT

PLEASE RESTRICT TRANSMISSION TO 69 CHARACTERS PER LINE

MESSAGE TO BE TRANSMITTED (Use double spacing and all capital letters)

TO:

DIRECTORS, ALVAMC AND REGIONAL OFFICES WITH OUTPATIENT CLINICS

00/136 THIS IS INTERIM ISSUE 10-80-71

A. BASIC ADMINISTRATIVE ISSUE AFFECTED: DM&S MANUAL M-1, PART I CHAPTER 17

B. OTHER ISSUES AFFECTED: NONE

C. REASON FOR ISSUE:

TO EXTEND PROVISIONS OF II 10-80-5

D. TEXT OF ISSUE:

INTERIM ISSUE 10-80-5, WHICH GRANTED AUTHORITY FOR THE FURNISHING OF MEDICAL SERVICES FOR ANY DISABILITY OF A VETERAN OF THE MEXICAN BORDER PERIOD OR WORLD WAR I, IS EXTENDED TO JANUARY 30, 1982.

E. RESCISSION: THIS ISSUE WILL NOT BE CONFIRMED BY A PRINTED ISSUE AND IS RESCINDED JANUARY 30, 1982. 136F/10

W B Thompson

DISTRIBUTION: RPC: 1108(CO AND NONVA ONLY)
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II 10-80-41

August 14, 1980

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE	SECURITY CLASSIFICATION
VACO WASH., D.C.	ACTION: INFO:	
ACCOUNTING CLASSIFICATION	DATE PREPARED 7/24/80	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS
FOR INFORMATION CALL		
NAME TONY RANCIATO (136F)	PHONE NUMBER 2337	

THIS SPACE FOR USE OF COMMUNICATION UNIT

RESTRICT TRANSMISSION TO 59 CHARACTERS PER LINE

MESSAGE TO BE TRANSMITTED (Use double spacing and all capital letters)

TO:

DIRECTORS, ALVAMC AND REGIONAL OFFICES WITH OUTPATIENT CLINICS

00/136 THIS IS INTERIM ISSUE 10-80-41

A. BASIC ADMINISTRATIVE ISSUE AFFECTED: DM&S MANUAL M-1, PART I, APPENDIX 17A

B. OTHER ISSUES AFFECTED: NONE

C. REASON FOR ISSUE: TO REVISE INSTRUCTIONS FOR THE 20 PERCENT SAMPLING OF VA FORMS 10-2875-1 AND 10-2875-2, OUTPATIENT ROUTING AND STATISTICAL ACTIVITY RECORD.

D. TEXT OF ISSUE: DM&S MANUAL M-1, PART I, APPENDIX 17A, PAGE 17A-3, PARAGRAPH 2G, LINE 7: INSERT: "WHEN SELECTING THE MONTHLY 20 PERCENT SAMPLING OF VA FORMS 10-2875-1 AND 10-2875-2, ONLY THOSE FORMS WITH A CATEGORY OF VISIT 1 THROUGH 6 CHECKED AND A SOCIAL SECURITY NUMBER ENDING IN 1 OR 5 ARE TO BE SUBMITTED. THE COMPUTER EDIT REJECTS ALL RECORDS CATEGORY OF VISIT 7 OR 8. THEREFORE, CONTROLS SHOULD BE ESTABLISHED TO INSURE THAT NO RECORDS WITH CATEGORY OF VISIT 7 OR 8 ARE SUBMITTED WITH THE 20 PERCENT SAMPLE."

E. THIS ISSUE WILL NOT BE CONFIRMED WITH A PRINTED ISSUE AND IS RESCINDED AUGUST 13, 1981. 137F/10

DISTRIBUTION: RPC: 1108(CO AND NONVA ONLY)
NS

Donald B Thompson

SECURITY CLASSIFICATION

AUG 14 1980

TRANCIATO:cbc 136F 136A 136 10

PAGE NO. 1 | NO. OF PGS. 1

609305 P

STANDARD FORM 14
REVISED AUGUST 1967
GSA FPMR (41 CFR) 101-30.306

U.S. GOVERNMENT PRINTING OFFICE 1970 O-397-251

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE	SECURITY CLASSIFICATION
VACO WASH., DC	ACTION: INFO:	
ACCOUNTING CLASSIFICATION	DATE PREPARED: 2/20/80	TYPE OF MESSAGE: ☐ SINGLE ☐ BOD ☐ MULTIPLE-ADDRESS
FOR INFORMATION CALL		
NAME: JEROME HANES (136F)	PHONE NUMBER: 2143	

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

DIRECTORS, VA MEDICAL CENTERS, MEDICAL AND REGIONAL OFFICE CENTERS, DOMICILIARY, OUTPATIENT CLINICS, AND REGIONAL OFFICES WITH OUTPATIENT CLINICS

00/136 THIS IS INTERIM ISSUE 10-80-15

A. BASIC ADMINISTRATIVE ISSUE AFFECTED: DM&S MANUAL M-1, PART I, CHAPTER 17

B. OTHER ISSUES AFFECTED: NONE

C. REASON FOR ISSUE: TO EXTEND THE PROVISIONS OF II 10-79-16 PENDING INCORPORATION IN THE MANUAL THAT ELIGIBLE VETERANS ENROLLED IN THE VA OUTPATIENT PROGRAM RECEIVE ALL MEDICAL SERVICES, MEDICATIONS, SUPPLIES AND BENEFITS, AS DEFINED IN SECTION 601(6), TITLE 38, U.S.C. TO WHICH THEY ARE ENTITLED.

D. TEXT OF ISSUE: THE RESCISSION DATE OF II 10-79-16 IS EXTENDED UNTIL APRIL 15, 1981.

E. RESCISSIONS: THIS INTERIM ISSUE WILL NOT BE CONFIRMED WITH A PRINTED COPY AND IS RESCINDED APRIL 15, 1981.

136F/10

for CO

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STANDARD FORM 14
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GSA FPMR (41 CFR) 101-35.304

U.S. GOVERNMENT PRINTING OFFICE : 1970 O-397-285

14-102

II 10-80-5
January 31, 1980

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE	SECURITY CLASSIFICATION
VACO WASH., DC	ACTION: INFO:	
ACCOUNTING CLASSIFICATION	DATE PREPARED 1/7/80	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS
FOR INFORMATION CALL		
NAME ROBERT PERREAULT (136F)	PHONE NUMBER 2851	

THIS SPACE FOR USE OF COMMUNICATION UNIT

RESTRICT TRANSMISSION TO 59 CHARACTERS PER LINE

MESSAGE TO BE TRANSMITTED (Use double spacing and all capital letters)

TO:
DIRECTORS, ALVAMC AND REGIONAL OFFICES WITH OUTPATIENT CLINICS

00/136 THIS IS INTERIM ISSUE 10-80-5

A. BASIC ADMINISTRATIVE ISSUE AFFECTED: DM&S MANUAL M-1, PART I, CHAPTER 17

B. OTHER ISSUES AFFECTED: NONE

C. REASON FOR ISSUE: TO ADVISE ALL VETERANS ADMINISTRATION MEDICAL ACTIVITIES THAT EFFECTIVE JANUARY 1, 1980 AUTHORITY IS GRANTED FOR THE FURNISHING OF MEDICAL SERVICES FOR ANY DISABILITY OF A VETERAN OF THE MEXICAN BORDER PERIOD OR WORLD WAR I (MEXICAN BORDER PERIOD AND WORLD WAR I ARE DEFINED IN VAR 6030). AUTHORITY IS ALSO GRANTED FOR THE FURNISHING OF HOME HEALTH SERVICES FOR VETERANS OF THE MEXICAN BORDER PERIOD, WORLD WAR I AND FOR VETERANS IN RECEIPT OF INCREASED PENSION OR ADDITIONAL COMPENSATION OR ALLOWANCE BASED ON THE NEED OF REGULAR AID AND ATTENDANCE OR BY REASON OF BEING PERMANENTLY HOUSEBOUND, OR WHO, BUT FOR RECEIPT OF RETIRED PAY WOULD BE IN RECEIPT OF SUCH PENSION, COMPENSATION, OR ALLOWANCE, SUBJECT TO TERMS AND CONDITIONS SET FORTH IN TITLE 38 USC 612(f). THIS ISSUE ALSO DESIGNATES THE APPROPRIATE PRIORITY FOR TREATMENT OF MEXICAN BORDER AND WORLD WAR I VETERANS.

SECURITY CLASSIFICATION

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1	3

14-102

STANDARD FORM 14
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II 10-80-5
January 31, 1980

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS
FOR INFORMATION CALL		
NAME	PHONE NUMBER	
THIS SPACE FOR USE OF COMMUNICATION UNIT		

MESSAGE TO BE TRANSMITTED (*Use double spacing and all capital letters.*)

TO:

D. TEXT OF ISSUE:

1. GENERAL

AUTHORITY FOR THIS CHANGE IS CONTAINED AMONG THE VARIOUS PROVISIONS OF PUBLIC LAW 96-151, VETERANS HEALTH PROGRAMS EXTENSION AND IMPROVEMENT ACT OF 1979.

2. SPECIFIC

DM&S MANUAL M-1, PART I, CHAPTER 17 IS CHANGED AS FOLLOWS:

(a) PAGE 17-8, PARAGRAPH 17.28a IS DELETED AND REPLACED BY THE FOLLOWING:

"a. ANY VETERAN OF THE MEXICAN BORDER PERIOD, WORLD WAR I, OR IN RECEIPT OF INCREASED PENSION OR ADDITIONAL COMPENSATION OR ALLOWANCE BASED ON THE NEED OF REGULAR AID AND ATTENDANCE OR BY REASON OF BEING PERMANENTLY HOUSEBOUND, OR WHO, BUT FOR RECEIPT OF RETIRED PAY WOULD BE IN RECEIPT OF SUCH PENSION, COMPENSATION OR ALLOWANCE MAY BE FURNISHED SUCH MEDICAL SERVICES AS ARE REASONABLY NECESSARY FOR ANY DISABILITY. (DENTAL CARE IS NOT INCLUDED.)"

(b) PAGE 17-8, PARAGRAPH 17.28 IS CHANGED BY ADDING SUBPARAGRAPH c. AS FOLLOWS:

SECURITY CLASSIFICATION	PAGE NO.	NO. OF PGS
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STANDARD FORM 14
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14-102

TELEGRAPHIC MESSAGE

II 10-80-5
January 31, 1980

NAME OF AGENCY	PRECEDENCE ACTION INFO.	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS
FOR INFORMATION CALL NAME	PHONE NUMBER	

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED (Use double spacing and all capital letters)

TO:

"c. ANY VETERAN INDICATED IN SUBPARAGRAPH a. ABOVE MAY BE FURNISHED HOME HEALTH SERVICES (INCLUDING ONLY SUCH IMPROVEMENTS AND STRUCTURAL ALTERATIONS THE COST OF WHICH DOES NOT EXCEED $600.00 FOR A NSC DISABILITY AS ARE NECESSARY TO ASSURE THE CONTINUATION OF TREATMENT OR PROVIDE ACCESS TO THE HOME OR TO ESSENTIAL LAVATORY AND SANITARY FACILITIES)."

(c) PAGE 17-13, PARAGRAPH 17.51 IS CHANGED BY AMENDING "PRIORITY II" TO READ AS FOLLOWS:

"VETERANS OF THE MEXICAN BORDER PERIOD, WORLD WAR I, OR IN RECEIPT OF INCREASED PENSION OR SPECIAL ALLOWANCE BASED ON THE NEED OF REGULAR AID AND ATTENDANCE OR BY REASON OF BEING PERMANENTLY HOUSEBOUND, OR WHO, BUT FOR RECEIPT OF RETIRED PAY, WOULD BE IN RECEIPT OF SUCH INCREASED PENSION OR SPECIAL ALLOWANCE."

E. RESCISSION: THIS ISSUE WILL NOT BE CONFIRMED BY A PRINTED ISSUE AND IS RESCINDED JANUARY 30, 1981.

136F/10

D B Thomas
for 10

Distribution: RPC: 1108(CO AND NONVA ONLY)
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STANDARD FORM 14
REVISED AUGUST 1967
GSA FPMR (41 CFR) 101-35.304

U.S. GOVERNMENT PRINTING OFFICE 1970 O-397-339

14-102

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE	SECURITY CLASSIFICATION
VACO WASH., DC	ACTION INFO	
ACCOUNTING CLASSIFICATION	DATE PREPARED 9/11/79	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS
FOR INFORMATION CALL		
NAME EMILIO CARRASCO (136F)	PHONE NUMBER 2337	

THIS SPACE FOR USE OF COMMUNICATION UNIT

RESTRICT TRANSMISSION TO 59 CHARACTERS PER LINE

MESSAGE TO BE TRANSMITTED (Use double spacing and all capital letters)

TO:

DIRECTORS, VA MEDICAL CENTERS, MEDICAL AND REGIONAL OFFICE CENTERS, DOMICILIARY, OUTPATIENT CLINICS, AND REGIONAL OFFICES WITH OUTPATIENT CLINICS
INFO: DPC, AUSTIN, TX

00/136 THIS IS INTERIM ISSUE 10-79-41

A. BASIC ADMINISTRATIVE ISSUE AFFECTED: DM&S MANUAL M-1, PART I CHAPTER 18

B. OTHER ISSUES AFFECTED: NONE

C. REASON FOR ISSUE: TO ADVISE ALL VETERANS ADMINISTRATION MEDICAL ACTIVITIES THAT EFFECTIVE JUNE 13, 1979:

(1) LIMITED AUTHORITY IS RESTORED TO VETERANS ADMINISTRATION MEDICAL ACTIVITIES ASSIGNED RESPONSIBILITY FOR ADMINISTERING THE FEE BASIS PROGRAM TO FURNISH FEE BASIS OUTPATIENT CARE TO VETERANS IN RECEIPT OF INCREASED PENSION BASED ON THE NEED OF REGULAR AID AND ATTENDANCE OR BY REASON OF BEING PERMANENTLY HOUSEBOUND ("A&A/HOUSEBOUND" VETERANS); AND

(2) REQUIREMENT IS ADDED THAT REVIEWS BE CONDUCTED PERIODICALLY FOR DETERMINING THE NECESSITY FOR CONTINUING CARE ON FEE OR CONTRACT BASIS IN THE CASE OF ANY VETERAN AUTHORIZED SUCH CARE.

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REVISED AUGUST 1967
GSA FPMR (41 CFR) 101-30.304

U.S. GOVERNMENT PRINTING OFFICE: 1968 O—297-286

14-102

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION INFO.	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS
FOR INFORMATION CALL		
NAME	PHONE NUMBER	

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED (Use double spacing and all capital letters)

TO:

D. TEXT OF ISSUE:

1. GENERAL

A. AUTHORITY FOR THESE TWO CHANGES IS CONTAINED AMONG THE VARIOUS PROVISIONS OF PUBLIC LAW 96-22, VETERANS' HEALTH CARE AMENDMENTS OF 1979, WHICH BECAME EFFECTIVE ON THE DATE OF ITS ENACTMENT, JUNE 13, 1979.

B. THIS LAW ALSO REQUIRES THAT THE VETERANS ADMINISTRATION SUBMIT TO CONGRESS NOT LATER THAN FEBRUARY 1, 1980, AND ANNUALLY THEREAFTER, FULL REPORTS ON THE NUMBER OF VETERANS PROVIDED FEE/CONTRACT TREATMENT, THE AVERAGE COST AND DURATION OF SUCH CARE IDENTIFIED BY EACH OF THE ELIGIBILITY/TYPE OF CARE CATEGORIES FOR EACH STATE, TERRITORY, POSSESSION, THE DISTRICT OF COLUMBIA AND THE COMMONWEALTH OF PUERTO RICO. INSTRUCTIONS FOR COMPLIANCE WITH THIS REQUIREMENT ARE BEING DEVELOPED FOR DISTRIBUTION IN A SEPARATE INTERIM ISSUE.

C. OTHER ISSUES RELATING TO MANUAL CHANGES, NEW OR AMENDED VA REGULATIONS, ETC., TO IMPLEMENT THE REMAINING PROVISIONS OF PUBLIC LAW 96-22 ARE NOW BEING DEVELOPED FOR DISTRIBUTION AS SOON AS EACH IS FINALIZED.

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STANDARD FORM 14
REVISED AUGUST 1967
GSA FPMR (41 CFR) 101-30.206

U.S. GOVERNMENT PRINTING OFFICE 1976 O—227-225

14-102

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION INFO	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE ADDRESS
FOR INFORMATION CALL		
NAME	PHONE NUMBER	
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MESSAGE TO BE TRANSMITTED (Use double spacing and all capital letters)

TO:

2. SPECIFIC

A. POLICIES GENERALLY PRESCRIBED IN DM&S MANUAL M-1, PART I, CHAPTER 18 ARE CHANGED TO:

(1) RESTORE EFFECTIVE JUNE 13, 1979 TO VETERANS' ADMINISTRATION MEDICAL FACILITIES DESIGNATED AS CLINICS OF JURISDICTION LIMITED AUTHORITY TO FURNISH FEE BASIS OUTPATIENT CARE FOR NONSERVICE-CONNECTED MEDICAL DISABILITIES OF VETERANS WHO ARE IN RECEIPT OF INCREASED PENSION BASED ON THE NEED OF REGULAR AID AND ATTENDANCE OR BY REASON OF BEING PERMANENTLY HOUSEBOUND. THIS AUTHORITY IS LIMITED IN THAT:

(A) THE GENERAL PRECONDITIONS PRESCRIBED FOR THE AUTHORIZATION OF FEE BASIS CARE FOR ANY OTHERWISE ELIGIBLE VETERAN MUST EXIST -- THE VETERANS ADMINISTRATION AT ITS FACILITIES, OR BY CONTRACT WITH OTHER GOVERNMENT MEDICAL FACILITIES, IS INCAPABLE OF PROVIDING CARE ECONOMICALLY BECAUSE OF GEOGRAPHICAL INACCESSIBILITY OR IS UNABLE TO PROVIDE THE REQUIRED CARE; AND

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STANDARD FORM 16
REVISED AUGUST 1967
GSA FPMR (41 CFR) 101-30.206

U.S. GOVERNMENT PRINTING OFFICE: 1979 O—287-555

16-102

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION INFO	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS
FOR INFORMATION CALL		
NAME	PHONE NUMBER	
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MESSAGE TO BE TRANSMITTED (Use double spacing and all capital letters)

TO:

(B) IN ADDITION, A DETERMINATION BASED ON AN EXAMINATION BY A PHYSICIAN EMPLOYED BY THE VETERANS' ADMINISTRATION (OR IN AREAS WHERE NO SUCH PHYSICIAN IS AVAILABLE, BY A PHYSICIAN CARRYING OUT SUCH FUNCTION UNDER A CONTRACT OR FEE ARRANGEMENT) MUST BE MADE THAT THE MEDICAL CONDITION OF SUCH A VETERAN PRECLUDES APPROPRIATE TREATMENT IN VETERANS' ADMINISTRATION MEDICAL ACTIVITIES OR BY CONTRACT WITH OTHER GOVERNMENT MEDICAL FACILITIES.

(2) REQUIRE THAT REVIEWS BE CONDUCTED PERIODICALLY TO DETERMINE THE NECESSITY FOR CONTINUING FEE OR CONTRACT BASIS CARE IN THE CASE OF ANY VETERAN AUTHORIZED SUCH CARE. REVIEWS IN CONNECTION WITH ID CARD FEE BASIS AUTHORIZATIONS WILL BE CONDUCTED ONE MONTH PRIOR TO THE EXPIRATION DATE OF THE AUTHORIZED VALIDITY PERIOD AT A FREQUENCY BASED ON EACH INDIVIDUAL VETERAN'S MEDICAL AND ELIGIBILITY STATUS BUT AT A MINIMUM OF AT LEAST EVERY THIRTY-SIX MONTHS FROM THE LATEST ISSUE DATE OF EACH AUTHORIZATION. TO ASSIST WITH THE REVIEW OF VETERANS ISSUED FEE BASIS ID CARDS THE AUSTIN DPC WILL PROVIDE EACH CLINIC OF JURISDICTION, TWO MONTHS PRIOR TO EXPIRATION DATES OF VALIDITY PERIODS SUBMITTED TO DPC FOR INCLUSION IN THE FEE BASIS

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STANDARD FORM 14
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GSA FPMR (41 CFR) 101-30.330

U.S. GOVERNMENT PRINTING OFFICE 1970 O-397-285

14-102

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION INFO	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS
FOR INFORMATION CALL		
NAME	PHONE NUMBER	
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MESSAGE TO BE TRANSMITTED (Use double spacing and all capital letters)

TO:

VETERANS MASTER RECORDS, LISTS IDENTIFYING THOSE VETERANS WHOSE VALIDITY PERIOD OF AUTHORIZATION IS DUE TO EXPIRE. THESE REVIEWS WILL BE CONDUCTED BY EITHER ONE OR A COMBINATION OF THE FOLLOWING METHODS: (A) REVIEW OF THE VETERAN'S MEDICAL RECORD, (B) CONSULTATION WITH THE FEE PARTICIPANT, OR, (C) VA STAFF PERSONAL EXAMINATION OF THE VETERAN. FROM THESE EVALUATIONS THE DETERMINATION WILL BE MADE TO: (A) CONTINUE FEE BASIS CARE BY ISSUING AN EXTENDED VALIDITY PERIOD, (B) TRANSFER OF THE VETERAN TO VA STAFF CARE, OR, (C) TERMINATE THE FEE BASIS CARE AUTHORIZATION. EACH DETERMINATION RESULTING FROM THESE EVALUATIONS WILL BE DOCUMENTED BY THE VA REVIEWING PHYSICIAN ON SF 509, DOCTOR'S PROGRESS NOTE, AND FILED IN THE VETERAN'S MEDICAL RECORDS.

E. RESCISSION: INTERIM ISSUE 10-79-18 IS RESCINDED. THIS ISSUE WILL NOT BE CONFIRMED IN A PRINTED INTERIM ISSUE AND IS RESCINDED SEPTEMBER 18, 1980. 136F/10

James C Cutchin

ECARRASCO:dw	136F	136	13	10	PAGE NO. 5	NO. OF PGS. 5	SECURITY CLASSIFICATION SEP 19 1979

STANDARD FORM 14
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14-102

TELEGRAPHIC MESSAGE II 10-79-40

NAME OF AGENCY	PRECEDENCE	SECURITY CLASSIFICATION
VACO WASH., DC	ACTION INFO	
ACCOUNTING CLASSIFICATION	DATE PREPARED 9/11/79	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE ADDRESS
FOR INFORMATION CALL		
NAME EMILIO CARRASCO (136F)	PHONE NUMBER 2337	

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED (Use double spacing and all capital letters)

TO:
DIRECTORS, VA MEDICAL CENTERS, MEDICAL AND REGIONAL OFFICE CENTERS, DOMICILIARY, OUTPATIENT CLINICS, AND REGIONAL OFFICES WITH OUTPATIENT CLINICS
INFO: DPC, AUSTIN, TX

00/136 THIS IS INTERIM ISSUE 10-79-40

A. BASIC ADMINISTRATIVE ISSUE AFFECTED: DM&S MANUAL M-1, PART I CHAPTER 17

B. OTHER ISSUES AFFECTED: NONE

C. REASON FOR ISSUE: TO ADVISE ALL VETERANS ADMINISTRATION MEDICAL ACTIVITIES THAT EFFECTIVE JUNE 13, 1979:

AUTHORITY IS EXPRESSLY PROVIDED TO INCLUDE IN THE PRIORITY CATEGORY FOR OUTPATIENT CARE AND SERVICES FOR NONSERVICE-CONNECTED DISABILITIES OF SERVICE-CONNECTED VETERANS RATED AT LESS THAN 50% ANY VETERAN BEING EXAMINED TO DETERMINE THE EXISTENCE OR RATING OF A SERVICE-CONNECTED DISABILITY.

D. TEXT OF ISSUE:

1. GENERAL

AUTHORITY FOR THIS CHANGES IS CONTAINED AMONG THE VARIOUS PROVISIONS OF PUBLIC LAW 96-22, VETERANS' HEALTH CARE AMENDMENTS OF 1979, WHICH BECAME EFFECTIVE ON THE DATE OF ITS ENACTMENT, JUNE 13, 1979.

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1	2	SEP 19 1979

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16-102

II 10-79-40

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION INFO	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE ADDRESS
FOR INFORMATION CALL		
NAME	PHONE NUMBER	

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED (Use double spacing and all capital letters)

TO:

2. SPECIFIC

DM&S MANUAL M-1, PART I, CHAPTER 17, PAGE 17-13, PARAGRAPH 17.51, PRIORITY I, SUBPARAGRAPH "c" IS CHANGED BY ADDING THE FOLLOWING NEW SENTENCE:

"THIS INCLUDES ANY VETERAN BEING EXAMINED TO DETERMINE THE EXISTENCE OR RATING OF A SERVICE-CONNECTED DISABILITY."

E. RESCISSION: THIS ISSUE WILL NOT BE CONFIRMED BY PRINTED ISSUE AND IS RESCINDED SEPTEMBER 18, 1980. 136F/10

James C Gratkin

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NS

ECARRASCO:dv 136F 136 13 10

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2	2

SECURITY CLASSIFICATION
597402.F

SEP 19 1979

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REVISED AUGUST 1967
GSA FPMR (41 CFR) 101-35.202

U.S. GOVERNMENT PRINTING OFFICE 1968 O-287-201

16-107

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE	SECURITY CLASSIFICATION
VACO WASH., DC	ACTION INFO.	
ACCOUNTING CLASSIFICATION	DATE PREPARED 3/16/79	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS
FOR INFORMATION CALL		
NAME JEROME HANES (136F)	PHONE NUMBER 2337	

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED (Use double spacing and all capital letters)

TO:

DIRECTORS, VA MEDICAL CENTERS, MEDICAL AND REGIONAL OFFICE CENTERS, DOMICILIARY, OUTPATIENT CLINICS, AND REGIONAL OFFICES WITH OUTPATIENT CLINICS

Extended by 10-80-25

00/136 THIS IS INTERIM ISSUE 10-79-16

A. BASIC ADMINISTRATIVE ISSUE AFFECTED: DM&S MANUAL M-1, PART I, CHAPTER 17

B. OTHER ISSUES AFFECTED: NONE

C. REASON FOR ISSUE: TO DIRECT THAT ELIGIBLE VETERANS ENROLLED IN THE VA OUTPATIENT PROGRAM RECEIVE ALL MEDICAL SERVICES, MEDICATIONS, SUPPLIES AND BENEFITS, AS DEFINED IN SECTION 601(6), TITLE 38, U.S.C.

D. TEXT OF ISSUE:

1. VETERANS PROPERLY ENROLLED IN AN AUTHORIZED OUTPATIENT PROGRAM WILL BE FURNISHED REQUIRED EXAMINATIONS, TREATMENTS, REHABILITATIVE SERVICES, MEDICATIONS AND SUPPLIES TO WHICH THEY ARE LEGALLY ENTITLED, AND WHICH HAVE BEEN ORDERED BY THE RESPONSIBLE PHYSICIAN. BENEFICIARY TRAVEL WILL BE PROVIDED WHEN ELIGIBILITY REQUIREMENTS THEREFOR ARE MET. PROGRAM CONTROLS AS STATED IN VA PROCEDURES WILL BE FOLLOWED.

2. HEALTH CARE FACILITY DIRECTORS WILL MAINTAIN ENROLLMENTS IN OUT-

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STANDARD FORM 14
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14-102

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION INFO	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS
FOR INFORMATION CALL		
NAME	PHONE NUMBER	
THIS SPACE FOR USE OF COMMUNICATION UNIT		

MESSAGE TO BE TRANSMITTED (Use double spacing and all capital letters)

TO:

OF AVAILABLE RESOURCES. THIS WILL BE ACCOMPLISHED THROUGH THE APPLICATION OF ESTABLISHED PRIORITIES AND PROCEDURES OUTLINED IN DM&S MANUAL M-1, PART I, CHAPTER 17, SECTION IX.

3. APPLICANTS WHO CANNOT BE ACCEPTED FOR OUTPATIENT SERVICES WILL BE REFERRED TO SOCIAL WORK SERVICE FOR COUNSELING REGARDING THE USE OF NON-VA HEALTH CARE RESOURCES. HOWEVER, IN INSTANCES WHERE VETERANS IN AFFECTED LOW PRIORITY GROUPINGS REQUIRE SERVICES NOT AVAILABLE TO THEM IN THE COMMUNITY, VA FACILITIES WILL MAKE A CONCERTED EFFORT TO PROVIDE THE NECESSARY CARE.

E. DETAILED MANUAL CHANGES WILL BE ISSUED AT A LATER DATE.

F. RESCISSION: THIS ISSUE WILL NOT BE CONFIRMED WITH A PRINTED COPY AND IS RESCINDED APRIL 16, 1980.

136F/10

JHANES:dw 136F 136 13 10	PAGE NO. 2	NO. OF PGS 2	SECURITY CLASSIFICATION APR 7 1979

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14-102

Question 2A. With reference to the agency's fee-basis ambulatory care program, what guidance does VACO provide to field stations regarding --

Question 2A(i). the criteria governing a veteran's eligibility for fee-basis care?

Answer 2A(i). Interim Issue 10-79-38, published September 20, 1979, lists the various categories of veterans' eligibility status on which statutory authority exists for the provision of fee-basis ambulatory care if specified criteria are met. The criteria, established by the same interim issue, specify that fee-basis care may be authorized to veterans with this special eligibility status only when it is determined by VA on an individual basis that (1) the VA, or by contract with another U.S. Government health care facility, is not capable of furnishing economical care because of geographical inaccessibility or (2) because neither of these facilities is capable of furnishing the required care or services. The provisions of this interim issue are being incorporated into DM&S Manual M-1, Part I, Chapter 18, which provides basic policy for fee-basis outpatient care.

Question 2A(ii). who is to make eligibility decision?

Answer 2A(ii). The VA physicians reviewing the medical needs of applicants for ambulatory care, with the assistance of administrative staff, make the decision concerning eligibility for fee-basis care. DM&S Manual M-1, Part I, Chapter 18 requires the authorizing physician to document on the veteran's medical records the reason for authorizing fee-basis status in lieu of providing VA staff treatment.

Question 2A(iii). the instructions to be given to the physician who will be treating the veteran on a fee basis as to the type of care authorized?

Answer 2A(iii). Fee-basis ambulatory care is generally authorized by issue of a numbered, accountable "ID" card. Disabilities for which treatment is authorized are listed by the authorizing facility on the ID card. In some cases only one specific disability is listed. In cases involving veterans with special eligibility status, such as service-connected rating of 50% or more, treatment may be authorized for any medical condition. These cards contain various preprinted instructions for the treating physician; e.g., this authorization is for outpatient medical treatment only; this card is restricted to the use of the veteran named on the reverse side and is valid only when signed by the veteran; and, not valid where VA medical facilities are available. Fee-basis care may also be authorized on a short-term basis. These authorizations are issued by use of special forms which specify the disability and treatment to be provided. These authorizations are used when the treatment is expected to be completed within a 60-day period.

Question 2B. Please provide copies of all current written guidance in these areas.

Answer 2B. Attached are copies of all current written guidance in these areas.

Veterans Administration
Department of Medicine and Surgery
Washington, D. C. 20420
September 20, 1979

FILE COPY DO NOT REMOVE

INTERIM ISSUE 10-79-38

A. BASIC ADMINISTRATIVE ISSUE AFFECTED: DM&S Manual M-1, Part I, Chapter 18

B. OTHER ISSUES AFFECTED: None

C. REASON FOR ISSUE: (1) To state policy consistent with the provisions of Public Law 94-581, Veterans Omnibus Health Care Act of 1976, regarding the authorization of care on a fee-for-services basis; (2) change the term "auxiliary services" to "medical supportive services"; (3) redefine qualification requirements for individuals who may be accepted as fee participants and re-emphasize that medical supportive services may be provided only at the prescription and direction of an authorized physician or osteopath; (4) direct that consideration be given to the selection of alternate methods of providing required home nursing services when economically feasible; (5) exclude mileage allowance costs paid to fee participants in the computation of the dollar monthly limitation for care with ID card authorization; (6) increase the dollar limitation from $40 to $55 as the maximum value of routine medical and nursing services which may be incurred during any calendar month with ID card authorization; and, as provided by PL 96-22, Veterans Health Care Amendments of 1979, effective June 13, 1979, (7) restore limited authority to furnish fee basis care to veterans who are in receipt of increased pension based on the need of regular aid and attendance or by reason of being permanently housebound (VAR 6060(I)); (8) require that periodic reviews be conducted for determining the necessity for continuing care on fee basis in the case of any veteran authorized such care.

D. TEXT OF ISSUE:

DM&S Manual M-1, Part I, Chapter 18 is changed as follows:

1. Page 18-1, paragraph 18.01, subparagraph a: Delete text and substitute with the following:

"Outpatient Treatment and Examination. Basic authorities are VA Regulations 6060(A) through 6060(D); 6060(F) through 6060(I) and 6060.1 (that portion applicable to allied beneficiaries only)."

2. Page 18-1, paragraph 18.02, subparagraph f: Delete text and substitute with the following:

"Supportive Medical Services. Refers to medical services provided by supportive professional or paraprofessional personnel at the prescription and direction of an authorized physician or osteopath. Supportive medical services include, but are not limited to treatment, care and services provided by podiatrists, psychologists, registered nurses, licensed vocational (or practical) nurses, laboratory technicians, radiological technicians, inhalation therapists and physical therapists. (Also see definition for 'fee participants', new subparagraph below.)"

3. Page 18-1, paragraph 18.02: Add new subparagraph as follows:

"j. Fee Participants. This term refers to 'hometown' physicians, osteopaths, optometrists, podiatrists, nurses, pharmacies, and other health care providers who provide treatment, services, medications, or supplies to veterans authorized to receive care at VA expense on a fee-for-services basis. The term 'fee vendors' is also frequently used by DPC and CALM staff when referring to this group of health care providers."

4. Page 18-2, paragraph 18.03: Delete subparagraphs a through c and substitute with the following:

"a. Fee basis care will be authorized for eligible veterans only when it has been determined by the VA on an individual basis that (1) VA, or other government health care facility by contract with the VA, is not capable of furnishing economical care because of geographical inaccessibility, or, (2) because the VA, or other government health care facility by contract with the VA, is not capable of furnishing the required care or services. These limitations, however, do not preclude a VA health care facility with limited resources from procuring by contract supportive medical services, such as laboratory or radiology examinations, treatment or services, needed for diagnostic purposes or to complete treatment initiated in their facility so long as the primary care and treatment responsibility remains with the staff of that VA health care facility.

"b. Subject to the provisions of subparagraph a, above, fee basis care may be authorized for:

(1) Outpatient treatment of a service-connected disability or a disability for which a veteran was discharged from the active military, naval or air service (including any disability of a Spanish-American War veteran), or

(2) Outpatient treatment for a nonservice-connected medical disability of a veteran who has service-connected disability(ies) rated at 50% or more, or

(3) Outpatient treatment for any disability of a veteran found in need of training authorized under 38 U.S.C., chapter 31, and for whom an objective has been selected or who is pursuing vocational rehabilitation

training, as may be required to prevent the delay or the interrruption of his or her approved rehabilitation program.

(4) Outpatient treatment where the veteran has been furnished hospital ca e and the recommended outpatient care is reasonably necessary to complete treatment incident to such hospital care. This treatment, both staff and fee combined, will not be for a period exceeding 12 months except when the VA attending physician finds that a longer period is required by virtue of the disability being treated and such findings and recommendations are recorded in the veteran's medical records.

(5) Treatment of medical emergencies which pose a serious threat to the health or life of a veteran receiving hospital care at a VA health care facility or receiving hospital care in a federal hospital at VA expense when either of these facilities is not capable of providing the required care or services.

(6) Outpatient treatment for a nonservice-connected medical disability of a veteran in receipt of increased pension based on the need of regular aid and attendance or by reason of being permanently housebound when it has been determined, based on an examination by a physician employed by the Veterans' Administration (or, in areas where no such physician is available, by a physician carrying out such function under a contract or fee arrangement), that the medical condition of such veteran precludes appropriate treatment in facilities over which the Administrator has direct jurisdiction or Government facilities for which the Administrator contracts. The following factors should be considered in making the determination of what constitutes "appropriate treatment": (a) long-standing relationships of these veterans with their non-VA physicians, and, (b) substantial adjustments these veterans and their families may have made in their living conditions in reliance upon the continuation of obtaining the care they require from non-VA physicians.

"c. Reviews will be conducted periodically to determine the necessity for continuing fee basis care in the case of any veteran authorized such care. These reviews will be conducted one month prior to the expiration date of the authorized validity period at a frequency based on each individual veteran's medical and eligibility status but at a minimum of at least every thirty-six months from the latest issue date of each authorization. To assist with the review of veterans issued fee basis ID cards the Austin DPC will provide each clinic of jurisdiction, two months prior to expiration dates of validity periods submitted to DPC for inclusion in the fee basis veterans master records, lists identifying those veterans whose validity period of authorization is due to expire. Factors for consideration in conducting these reviews will include the veteran's current medical needs, eligibility status, and any changes of residence which may have moved the veteran closer to a VA medical activity. These reviews will be conducted by either one or a combination of

the following methods: (1) review of the veterans medical records, (2) consultation with the fee participant, or (3) VA staff personal examination of the veteran. From these evaluations the determination will be made to: (1) continue fee basis care by issuing an extended validity period, (2) transfer of the veteran to VA staff care, or, (3) terminating the fee basis care authorization. Each determination resulting from these evaluations will be documented by the VA reviewing physician on SF 509, Doctor's Progress Note, and filed in the veteran's medical records."

5. Page 18-2, paragraph 18.03: Add the following four new subparagraphs:

"d. The policies and procedures of the outpatient fee basis program are based on the presumption that physicians, nurses, and other health care providers participating in the program will provide medical care consistent with sound judgment and ethical medical practices. Care provided by supportive medical care providers such as psychologists, nurses, technicians, therapists, and others will be authorized only when such care is at the prescription and direction of an authorized physician or osteopath. The term 'medical care' as used here means professional or supportive medical services rendered to the veteran personally. It does not include services provided during the absence of the veteran such as the relaying of medical advice through a third party or the telephoning to a pharmacy to authorize the refill of prescriptions for medications. Domestic type services such as preparation of meals, house cleaning, shopping, companionship, and other types of services associated with daily non-medical needs of the veteran do not constitute medical care and will not be authorized.

"e. Physicians and nurses who are citizens of the United States and who meet appropriate licensure and/or registration requirements for the state in which services are to be rendered are eligible to participate in the program. Noncitizens may be utilized when there are no qualified citizens available. Physicians, nurses, and other medical care providers who may not be employed in the Department of Medicine and Surgery without Central Office (054D) consultation may not treat veterans as VA beneficiaries unless the Clinic Director has obtained approval from the Chief Medical Director for using their services. Military physicians on active duty with the armed forces, engaged in limited medical practice after duty hours with the permission of their commanding officers, may not participate in the fee basis program.

"f. Supportive medical care providers (psychologists, nurses, etc.) duly licensed or registered in the state, or subdivision thereof, may be accepted as fee participants when services provided are those for which they qualify as recognized by the authorities in the state, or subdivision thereof, where the services are to be provided.

"g. Health care providers meeting the above requirements and who are relatives of a veteran should not be excluded from participating as a fee participant in the care of that veteran, merely because of their relation-

ship, when these individuals provide the same or similar services to the general public for remuneration. Excluded, however, are those relatives and other individuals who have been provided short-term training to provide post-hospital care to a veteran. This latter group would include, but not be limited to, persons trained to operate hemodialysis equipment, to provide assistance to spinal cord injury patients, or, to assist patients on the hospital based home care program."

6. Page 18-10, paragraph 18.34: Delete text and substitute the following:

"SUPPORTIVE MEDICAL SERVICES RECOMMENDED BY A PRIVATE PHYSICIAN

Supportive medical services must be prescribed by a physician or osteopath. The treating physician is expected to estimate the total cost of his or her services plus the cost of supportive medical services of other physicians or other health care providers he or she recommends."

7. Page 18-10, paragraph 18.35: Delete the term "auxiliary services" in all places it appears in this paragraph and substitute with the term "supportive medical services."

8. Page 18-10, paragraph 18.36: Add the following new subparagraph:

"e. Home nursing services will normally only be authorized on fee basis when it has been determined that such services will be required only for a reasonably short period of time and that such services will not be required on a daily basis. The estimated cost of the required home nursing services, plus the estimated costs of adjunct physician and pharmacy services on fee basis, for each individual veteran being considered for fee basis home nursing services authorization must be weighed against the estimated costs of alternate VA programs available to meet the veteran's individual needs. Such VA programs include, but are not limited to VA nursing home care, community nursing home care at VA expense, or hospital based home care. The most appropriate VA program to meet the veteran's needs will then be authorized. The decisive factors which lead to the selection of the final method for providing the required care authorized will be documented on SF 509 and filed in the veteran's outpatient treatment folder."

9. Page 18-11, paragraph 18.40, subparagraph a, line 1: Delete "$40" and insert "$55".

10. Page 18-11, paragraph 18.40, subparagraph c, line 2: Delete phrase ", and mileage allowances paid to a fee participant,".

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September 20, 1979

11. Page 18-12, paragraph 18.43, subparagraph a, line 1: Delete "auxiliary" and insert "supportive".

12. Page 18-14, paragraph 18.53, subparagraph a, line 5: Delete "$40" and insert "$55".

13. Page 18-15, paragraph 18.57, subparagraph b, line 3: Delete "$40" and insert "$55".

E. This interim issue will be incorporated in the forthcoming revision of Chapter 18, M-1, Part I.

F. RESCISSION: This interim issue expires September 19, 1980.

for JAMES C. CRUTCHER, M.D.
Chief Medical Director

Distribution: RPC: 1111
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II 10-80-51
September 17, 1980

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE	SECURITY CLASSIFICATION
VACO, WASHINGTON, D.C. 20420	ACTION INFO.	
ACCOUNTING CLASSIFICATION	DATE PREPARED 8/27/80	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS
FOR INFORMATION CALL		
NAME Emilio Carrasco	PHONE NUMBER 2337	

THIS SPACE FOR USE OF COMMUNICATION UNIT

RESTRICT TRANSMISSION TO 69 CHARACTERS PER LINE

MESSAGE TO BE TRANSMITTED (Use double spacing and all capital letters)

TO: DIRECTORS, ALVAMC AND REGIONAL OFFICES WITH OUTPATIENT CLINICS

00/136 THIS IS INTERIM ISSUE 10-80-51

A. BASIC ADMINISTRATIVE ISSUE AFFECTED: DM&S MANUAL M-1, PART I, CHAPTER 18

B. OTHER ISSUES AFFECTED: NONE

C. REASON FOR ISSUE: TO EXTEND THE PROVISIONS OF INTERIM ISSUE 10-79-38, DATED SEPTEMBER 20, 1979, WHICH PROVIDES AUTHORITY TO ESTABLISH LIMITATIONS ON THE PROVISION OF FEE-BASIS CARE; CHANGES THE TERM "AUXILIARY SERVICES" TO "MEDICAL SUPPORTIVE SERVICES"; REDEFINES QUALIFICATION REQUIREMENTS FOR FEE PARTICIPANTS; INCREASES THE DOLLAR LIMITATION FOR ROUTINE FEE-BASIS ID CARD CARE; RESTORES LIMITED AUTHORITY TO PROVIDE FEE-BASIS CARE TO VETERANS IN RECEIPT OF AID AND ATTENDANCE ALLOWANCES; AND REQUIRES THAT PERIODIC REVIEWS BE CONDUCTED TO DETERMINE THE NECESSITY OF CONTINUING FEE-BASIS CARE AUTHORIZATIONS.

D. TEXT OF ISSUE: THE RESCISSION DATE OF II 10-79-38 IS EXTENDED UNTIL SEPTEMBER 18, 1981.

E. RESCISSION: THIS INTERIM ISSUE WILL NOT BE CONFIRMED WITH A PRINTED COPY AND IS RESCINDED SEPTEMBER 18, 1981. 136F/10: KB Thompson for 10

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estimate may be made during the month as necessary. At the end of each month, the estimated amount will be adjusted and closed out for the total dollar value of invoices received for fee-basis pharmaceuticals during the month.

b. In lieu of listing each veteran's name or identification number and the approved amount of each invoice, entries in appropriate columns will reflect: (1) batch number and date; (2) total dollar value of invoices represented by the batch number; and (3) cumulative totals.

18.28-18.30 (Reserved.)

SECTION V. ESTABLISHING FEE-BASIS STATUS

18.31 BASIC CRITERIA

a. The provisions of paragraphs 16.02 and 16.14 will apply. Fee-basis treatment will not be approved unless outpatient or nursing services are currently required.

b. The authority to approve outpatient fee-basis status is the responsibility of the Clinic Director at the field station having an authorized fee-basis activity with assigned jurisdiction over the area in which the veteran has established permanent residence.

c. Veterans changing permanent residence within the jurisdictional area of the station which authorized fee-basis treatment will be provided staff, in lieu of fee-basis, treatment at that station or another available and suitable VA facility when the veterans' new location renders this feasible. A permanent change of address involving a change in station of jurisdiction will be processed in accordance with chapter 5. The receiving station will arrange for continuing staff or fee-basis treatment, as appropriate.

18.32 ID CARD FEE STATUS

a. Veterans, not temporarily or permanently residing in foreign countries or the Republic of the Philippines, who are eligible for fee-basis treatment and who require medical and/or nursing services for an extended or indefinite period, will be issued an ID card. This card may be used by the veteran to obtain outpatient medical services from a licensed physician or osteopath of his choice for the approved disability(ies) recorded on the card. Nursing services will be arranged by the Chief, Nursing Service. (See par. 18.36.) Normally, an ID card authorization will not terminate unless it is *known* that the need for medical or nursing services is no longer required. When the ID card authorizes "treatment for any condition," needed determination of refractive error may be obtained from an optometrist. Eyeglass prescriptions must be sent to the station of jurisdiction.

b. The Clinic Director may authorize treatment and/or home nursing services for disabilities for which the veteran is entitled to treatment or adjunct conditions in addition to the primary disability responsible for establishing ID card status. SF 509, Doctor's Progress Notes, will be annotated by the authorizing physician to reflect the service-connected and other disabilities approved for treatment, and the reason for authorizing a fee-basis status in lieu of providing staff treatment.

See II 10-82-1 (1/19/82)

c. An ID card will be reissued when loss or card deterioration is reported, a change in service connection occurs, or the Clinic Director determines a service connected or adjunct disability is to be added to or deleted from the card. Unserviceable cards will be replaced after their receipt by the station. In all instances, VA Form 10-1174 will be prepared locally.

d. Veterans, who have an ID card fee status terminated will be notified of the date entitlement will be terminated. They will be instructed to return the card. The next of kin will be requested to return the ID card for a deceased veteran. A mailing indicia envelope may be provided for this purpose. Followup requests to return ID cards are not required.

CHAPTER 16. OUTPATIENT CARE--GENERAL

SECTION I. GENERAL

16.01 DEFINITIONS AND TITLES

a. **Outpatient**. A person who receives medical services from VA staff, or under VA authorization on a fee basis, and who is not an occupant of a hospital, domiciliary or nursing home bed during the time these services are rendered.

b. **Clinic**. As used in this chapter "clinic" means all outpatient clinics including hospital outpatient services.

c. **Clinic Director**. The term "Clinic Director" means the physician in charge of an outpatient clinic or outpatient service of a VA hospital.

d. **Chief, Medical Administration Division**. This title refers also to the Chief, Medical Administration Service, in hospitals and centers and Chief Medical Administration Officer in independent clinics.

SECTION II. POLICY

16.02 UTILIZATION OF STAFF AND FEE-BASIS FACILITIES

"Treatment will be furnished, to the extent practical, on a staff basis at the VA medical activity with appropriate facilities nearest the veteran's home. Treatment, however, may be furnished on a fee basis when the criteria for authorizing such care as prescribed in paragraph 18.03 are met."

SECTION III. AUTHORITY FOR FURNISHING OUTPATIENT CARE

16.03 BASIC AUTHORITY

a. **Outpatient Medical Treatment**. Basic authorities are VA Regulations 6060, 6033, and 6045.1.

b. **Outpatient Dental Treatment**. Basic authorities are VA Regulations 6060[, 6060.1, 6060.2, 6060.3, 6120, 6123, 6123.1, 6123.2 and 6124.] (See ch. 19 for policies and procedures.)

~~c. **Transportation**. Basic authority is VA Regulation 6100. (Transportation, including ambulance and attendant travel, will be authorized and processed for payment by the VA station to which the veteran is reporting, except in unusual instances.)~~

SECTION IV. RESPONSIBILITY FOR DETERMINATION OF ELIGIBILITY FOR OUTPATIENT MEDICAL TREATMENT

16.04 GENERAL

While the overall responsibility for providing outpatient medical treatment is that of the Director of the hospital, center or clinic, the specific responsibility for establishing eligibility is as follows:

a. Legal eligibility for treatment will be determined by appropriate administrative personnel assigned this function.

b. Determination of medical need will be the responsibility of VA physician(s) assigned this function.

SECTION V. PROCESSING APPLICATIONS AND DETERMINING ELIGIBILITY FOR OUTPATIENT MEDICAL TREATMENT

16.05 APPLICATION PROCEDURES

a. **General.** Requests for medical treatment may be made by the veteran, or in his behalf by a physician or other representative on VA Form [10-10, Application for Medical Benefits,] or by letter, telegram or telephone. Requests by telephone, and action taken thereon, will be properly recorded and signed by the person processing the request.

b. [**Application.** Complete VA Form 10-10, Application for Medical Benefits, except for items 6, 8, 10, 11, 18, 19, 20, 21, 22 and 23.]

[c.] **Processing Applications.** If eligibility cannot be established on the basis of documentation in the outpatient treatment folder, the application [ ] or its equivalent will be reviewed by appropriate medical administrative personnel to establish eligibility. When the applicant is [ ] eligible, the Clinic Director or his designee will determine whether treatment will be rendered at a VA clinic or by a fee-basis physician. [ ]

[d.] **Notification to Veteran of Action Taken on Application.** The veteran will be informed of his eligibility for requested treatment and treatment authorized. He will be informed in person if he is present in the clinic and an appropriate notation made in the file. If he is not present in the clinic, notification will be as follows:

(1) **Eligible.** He will be informed by letter, VA Form [07-]3542, Authorization to Report–Voucher for Mileage Allowance, or other suitable means.

(2) **Ineligible.** If the applicant is ineligible, an individually typed letter with an adequate explanation, over the signature of the appropriate professional or administrative staff person, will be mailed to the veteran. A copy will be sent to the person or service representative having power of attorney, if this information is available in the outpatient treatment file.

— [e.] **Rejected Applications.** If the applicant is determined legally ineligible, or not in need of care, the rejected application and copies of related correspondence will be filed in the outpatient treatment folder if one exists. If a folder does not exist, the material will be disposed of in accordance with DM&S Records Control Schedule 10-1.

16.06 DETERMINATION OF LEGAL ELIGIBILITY FROM LOCAL RECORDS

Determination of legal eligibility will be made on the basis of information contained in the outpatient treatment folder, administrative records or claims folder whenever this is possible. The legal eligibility portion on [the application] will [ ] be completed showing the [authority for treatment. The application will then be] processed in accordance with local procedures.

16.07 DETERMINATION OF MEDICAL NEED

After legal eligibility has been established, medical need for care will be determined by a VA physician. [ ] This determination includes consideration for adjunct treatment when required.

"16.08 DETERMINATION OF ELIGIBILITY FOR PATIENTS REQUIRING IMMEDIATE CARE

a. Use of BIRLS When Location of Claims File Is Not Known. A fast response teletype message will be transmitted to BIRLS. The source material, such as correspondence and applications may be used, at the discretion of local management, as an input document in lieu of the designated code sheet. (See MP-6, pt. XIX, Supp. No. 2.1, and Supp. 3.1, for instructions on BIRLS.)

CHAPTER 21. NON-VA HOSPITALIZATION IN THE UNITED STATES

SECTION I GENERAL

21.01 SCOPE

This chapter contains policies and procedures relating to care for VA beneficiaries in non-VA hospitals, except care procured under agreements as authorized by VA Regulation 6210. Instructions for development and utilization of mutual use and exchange of use agreements are in [chapter 1.]

21.02 DEFINITIONS

a. For the purposes of this chapter, hospitals, other than those under the direct and exclusive jurisdiction of the VA, are classified either as other Federal or Non-Federal. Federal hospitals are further classified as hospitals with [agreements for] bed allocation to the VA [or without agreements for] bed allocation to the VA. Non-Federal hospitals may be contract or noncontract. A contract hospital is one with which the VA has negotiated a formal contract in accordance with paragraph 21.12a. A noncontract hospital is one with which the VA does not have a formal contract but whose services may be utilized on an individually authorized basis.

b. (1) The title, Chief, Medical Administration Division, includes Chief, Medical Administration Service, and Chief Medical Administration Officer.

(2) Clinic Director includes Chief of Outpatient Services at hospitals which have responsibility for fee-basis treatment programs.

(3) Fiscal Division includes Business Services Division.

c. The term "States" means each of the several States, territories, possessions of the United States, the District of Columbia, and the Commonwealth of Puerto Rico.

21.03 ELIGIBILITY

a. VA Regulation 6047 is the basic authority to hospitalize veterans in non-VA hospitals.

b. The provisions of chapter 4 apply in determining an applicant's eligibility for hospital care.

c. The provisions of chapter 17 apply in determining an applicant's eligibility for pre-bed and posthospital care.

21.04 UTILIZATION

a. VA Regulations 6050 through 6050.5 prescribe the use of non-VA hospitals.

b. The general principle to be observed in the utilization of non-VA hospitals is as follows: Non-VA hospitals will be used only when facilities under the direct and exclusive jurisdiction of the VA are not feasibly available, or when the urgency of the applicant's condition, the relative distance involved, or the nature of the treatment required in the individual case makes it necessary or economically advisable to utilize such institution instead of a VA hospital. Federal hospitals with a bed allocation to the VA, if they are feasibly available, will be used in preference to other non-VA hospitals. Contract non-Federal hospitals will be used in preference to noncontract non-Federal hospitals.

c. Persons retired for disability from military service may not be hospitalized in other Federal hospitals as beneficiaries of the VA except that persons retired for disability who require care for a chronic condition, as defined in VA Regulation 6048 (C), may be hospitalized in Alaska and Hawaii in other Federal hospital beds that have been allocated to the VA. (See app. 21C.)

d. Hospital facilities described below may be used in accordance with the following chart, subject to the above limitations.

Question 3A. Approximately what proportion of the fiscal year 1981 fee-basis costs were expended because of --

geographical inaccessibility to a VA facility?

Answer 3A. Statistics on this subject have not been kept.

Question 3B. VA's inability to furnish the care and services required?

Answer 3B. Statistics on this subject have not been kept.

Question 4A. Are the criteria for determining geographic inaccessibility to a VA medical facility applied in a uniform manner throughout the system?

Answer 4A. There is doubt that the determination of what constitutes geographic inaccessibility is being applied uniformly throughout the system. This is because a definition for the term "geographic inaccessiblity" has not been published. It is suspected that some medical facilities may be using an arbitrary mileage boundary to authorize fee-basis care to veterans with special eligibility status who may reside beyond such a boundary. This will be corrected in the forthcoming publication of the revision of DM&S Manual M-1, Part I, Chapter 18 which will include a definition of that term for systemwide application.

Question 4B(i). What guidance does VACO provide to field facilities that they fully consider referral of a veteran to another VA or other U.S. Government facility that is reasonably accessible to the veteran in lieu of authorizing fee-basis care?

Answer 4B(i). Interim Issue 10-79-38, published September 20, 1979, established the criteria that fee-basis care may

be provided to veterans with special eligibility status only when it has been determined that the required care and services could not be provided by VA or by contract with another U.S. Government medical facility. DM&S Manual M-I, Part I, Chapter 16, Outpatient Care-General directs that "treatment will be furnished, to the extent practical, on a staff basis at the VA medical activity with appropriate facilities nearest the veteran's home." Treatment on fee-basis is permitted when the criteria for authorizing such care as prescribed in Chapter 18 are met. Chapter 21 of the same manual directs that Federal hospitals be used in preference to other non-VA hospitals. Although this chapter pertains to non-VA hospitalization, it has been long-standing policy to also use Federal hospitals in preference to other non-VA sources for the provision of outpatient care when such care cannot be provided by VA.

Question 4B(ii). What actions have been taken to encourage field facilities to make referrals primarily to other VA and other U.S. Government facilities that are reasonably accessible?

Answer 4B(ii). The importance of following the directives cited above has been repeatedly mentioned at conferences and stressed in field surveys and visits.

Question 4B(iii). What evidence do you have to indicate whether VA field facilities attempt first to make referrals to other VA and other U.S. Government facilities before arranging for fee-basis care?

Answer 4B(iii). None.

Question 5A. How many obstetricians and gynecologists does the VA currently employ?

Answer 5A. As of March 31, 1982, the VA employed 14 full-time and 8 part-time physicians board-certified in Obstetrics and Gynecology. Of these, only 1 has a specialty assignment as a surgical gynecologist.

Question 5B(i). What plans do you have for increasing the direct provision of obstetrical and gynecological services by VA physicians?

Answer 5B(i). There are no specific plans to increase the direct provision of obstetrical and gynecological services by VA physicians. Under the Department of Medicine and Surgery's Medical District Initiated Program Planning (MEDIPP) process, it is the responsibility of the individual districts to determine what the veteran's needs, within their geographical area of responsibility, are and to propose plans which will meet those needs.

Question 5B(ii). Please provide information setting forth the numbers of obstetricians and gynecologists that the agency estimates it will employ in each of the next five fiscal years and the number of stations that will have such physicians assigned on a full- or part-time basis.

Answer 5B(ii). The number of obstetricians and gynecologists that will be employed will be determined by the districts based on the needs assessment.

Question 5C. Are there plans to make the services of these physicians available in areas where they can serve patients of more than one VAMC?

Answer 5C. Planning is a district wide process and districts are encouraged to share resources, to the extent possible, among Medial Centers within the district.

Question 6A. Section 401 of Public Law 96-330 amended section 622 of title 38 to repeal the provision of law that precluded the VA from looking behind the oath of inability to pay that a veteran may take in order to be eligible for VA medical care. To date, the VA has yet to issue regulations on how the agency will determine the veteran's ability to pay for the care.

What are the current plans for promulgating regulations to implement section 401 of Public Law 96-330?

Answer 6A. We are reluctant to attempt to project a specific date at this time. Efforts to develop a fair and workable screening apparatus are proceeding steadily. Such regulations must, of course, be approved by the Office of Management and Budget.

Question 6B. When will those regulations be forthcoming?

Answer 6B. These regulations must be approved by OMB. When that approval is received the regulations will be published in the Federal Register for the usual public comment period.

Question 6C. What is the current best estimate of the number of veterans per year seeking outpatient treatment on an "obviate" basis who would be denied such treatment because they are unable to defray the cost of the hospital care involved?

Answer 6C. We cannot project a meaningful estimate of the number of veterans who might be denied a particular mode of VA care in the absence of agreement on a specific screening apparatus to be applied.

Question 6D. With reference to determining the ability to pay of a veteran seeking ambulatory care to obviate the need for hospital care, the legislative history (see p. 24 of Senate Report 93-54 to accompany S. 59 and p. 13 of House Report 93-368 to accompany H.R. 9048) is clear that the cost of care that is to be considered in such a situation is tne "necessary expenses of the hospital care" which would be obviated. Is this the approach that the agency is following in developing regulations to implement section 401?

Answer 6D. The Agency has not adopted the regulatory framework which is contemplated by this question. Absent completion of that framework, the VA cannot advise the Congress of a methodology by which we would make cost-of-care determinations.

Question 6E(i). In the case of a veteran who applies for care and, after being provided a medical examination, is determined not to be eligible for care, do you plan to charge the veteran for the cost of the examination?

Question 6E(ii). If you do plan to charge some or all such veterans for such costs, please describe the circumstances under which you are considering doing so and describe the procedure you would folow in making the billings?

Question 6E(iii). In the case of a service-connected veteran seeking care for a nonservice-connected condition, do you plan to charge the veteran for the cost of the examination?

Question 6E(iv). In the case of a veteran seeking care for a condition the veteran claims is service-connected but which the agency, after providing an examination, determines not to be service-connected, do you plan to charge the veteran for the cost of the examination?

(a) If so, won't that discourage veterans from applying for service-connected care to which they may well be entitled?

(b) If not, need a veteran in order to avoid the possibility of a subsequent charge for the examination, accompany the application for care with the claim that the condition for which care is sought is service-connected?

Question 6E(v). Please provide legal analyses that support your authority regarding the various categories of veterans whom you plan to charge and not to charge for the costs of examinations?

Answers 6E(i), (ii), (iii), (iv), (v). Our General Counsel's Office has explored with operating elements possible means for operating a screening program; this has included discussions, in the abstract, regarding the possibility of billing certain veterans who are deemed able to defray the cost of care for the cost of their initial medical examinations. No plans have been established to pursue such a recovery theory.

Question 7A(i). With reference to the Agency's current efforts to bill VA employees for medical care received on the basis of taking the oath of inability to pay at VA facilities between 1978 and the present, please indicate, in terms of dollars, episodes of care, and number of individuals being billed - -

The numbers relating to the care that the VA has identified as incorrectly provided that was inpatient care and outpatient care:

Answer 7A(i). The VA identified 465 employees who obtained 488 episodes of inpatient care at a total cost of $574,632.00, and 373 employees who received 2,641 outpatient visits at a total cost of $108,281.00.

Question 7A(ii). The numbers relating to the cost for which billings have been made.

Answer 7A(ii). The VA has billed 457 employees for 480 episodes for inpatient care for a total cost of $565,200.00, and 365 employees for 2,584 outpatient visits for a total cost of $105,944.00.

Question 7B. Please state the amounts that have been collected.

Answer 7B. The VA has collected $96,555.00 for 82 episodes of inpatient care and $18,287.00 for 446 outpatient visits.

Question 7C. Please state the number of waivers of liability for the cost of care, together with the total dollar amounts involved that have been sought, granted, and denied, and that are still pending.

Answer 7C. A total of 101 waivers for inpatient care have been sought, representing a total of $124,815.00. Of these, 31, representing $37,681.00 have been granted; 14 representing $17,662.00 have been denied; and 56 representing $69,472.00 are still pending.

A total of 81 waivers for outpatient care have been sought, representing a total of $23,512.00. Of these, 6, representing $1,742.00 have been granted; 3 representing $870.00 have been denied; and 72 representing $20,900.00 are still pending.

Question 7D. Please provide the average income and lowest and highest income of those billed and any other tabular data readily available in the 465 cases.

Answer 7D. The average annual income of veterans billed was $20,800.00. The lowest was $15,027.00, and the highest was $47,025.00.

Attached is a tabular presentation of salaries, care, and costs.

COMPOSITE TOTAL BY SALARY LEVEL OF POTENTIAL COST RECOVERY CASES

Salary Range	Cases	IP Days	OPT Visits	IP Costs	OPT Costs	Total Costs
$15,000	75	814	354	$112,332	$14,514	$126,846
16,000	70	680	541	93,840	22,181	116,021
17,000	57	466	382	64,308	15,662	79,970
18,000	55	373	322	51,474	13,202	64,676
19,000	43	319	258	44,022	10,578	54,600
20,000	23	248	123	34,224	5,043	39,267
21,000	24	260	107	35,880	4,387	40,267
22,000	18	218	100	30,084	4,100	34,184
23,000	8	60	55	8,280	2,255	10,535
24,000	6	33	35	4,554	1,435	5,989
25,000	2	12	6	1,656	246	1,902
26,000	14	124	101	17,112	4,141	21,253
27,000	4	40	25	5,520	1,025	6,545
28,000	10	53	56	7,314	2,296	9,610
29.000	3	4	4	552	164	716
30,000	4	55	--	7,590	--	7,590
31,000	2	14	5	1,932	205	2,137
32,000	3	11	10	1,518	410	1,928
33,000	4	11	5	1,518	205	1,723
35,000						
36,000	3	39	9	5,382	369	5,751
37,000	2	3	8	414	328	742
38,000	3	75	4	10,350	164	10,514
39,000	1	7	--	966	--	966
40,000	3	9	2	1,242	82	1,324
41,000						
42,000	2	4	4	552	164	716
43,000	4	32	9	4,416	369	4,785
44,000	4	34	11	4,692	451	5,143
45,000	4	37	3	5,106	123	5,229
46,000						
47,000	12	106	97	14,628	3,977	18,605
	465	4,164	2,641	$574,632	$108,281	$682,913

Question 7E. Are there plans to extend the efforts to collect from VA employees for care received at VA medical facilities prior to 1978?

Answer 7E. There are no plans being contemplated to extend the efforts to collect from VA employees for care received at VA medical facilities prior to 1978.

Question 7F. Are there any plans to extend these collection efforts to other Federal employees and other veterans who received care in VA facilities?

Answer 7F. Plans are being formulated to extend the VA's collection efforts to other Federal employees and other veterans who may have been able to defray the costs of care for non-service-connected disabilities.

Question 8A. In your testimony, you make reference to the projected increase in demand for women's medical care as a partial result of treating more CHAMPVA eligibles in VA facilities pursuant to the amendment to the CHAMPVA authority made by section 105 of Public Law 97-72 that expands your authority to treat CHAMPVA eligibles in VA facilities.

Please describe, and provide a timetable for, the steps you have taken or planned to implement this authority.

Answer 8A. Directives have been published and distributed to our field facilities which amend the policy manuals regarding the providing of medical services to CHAMPVA beneficiaries at VA medical facilities.

The policy was amended to incorporate the expanded authority provided by Section 105 of Public Law 97-72 which permits use of VA medical facilities that are equipped to provide the required treatment to CHAMPVA beneficiaries if these facilities are not being utilized in the care of eligible veterans and using these facilities for the treatment of CHAMPVA beneficiaries would not interfere with the treatment of eligible veterans.

Question 8B. What impact on the overall demand for VA outpatient care will implementation of that amendment have?

Answer 8B. An increase in demand for VA outpatient care will be experienced as a result of this expanded authority. However, the decision as to whether the care will be provided to a CHAMPVA beneficiary in a VA medical facility or by civilian sources under the CHAMPVA program will be determined on an individual basis and will be dependent upon the facility being equipped to provide the treatment and the availability of resources not being utilized in the care of eligible veterans.

In FY 1983, we will assess VA medical centers with low occupancy rates, and if there is a high CHAMPVA population in the catchment area, test the impact of a major health care delivery change on our mandated clients and CHAMPVA clients.

Question 9A. At present, how many Agent Orange Registry examinations per month does the VA give?

Answer 9A. We have been averaging 2,800 exams per month for the Agent Orange Registry.

Question 9B(i). How many of these exams per month do you project during the next two fiscal years?

Answer 9B(i). It is projected that 57,000 exams will be performed during the next two fiscal years. It is estimated that 2,500 exams will be performed per month in FY 83 and 2,300 exams per month for FY 84.

Question 9B(ii). What effect will projected changes in the numbers of these exams have on the VA's ability to provide routine outpatient care?

Answer 9B(ii). It is not anticipated that the numbers of Agent Orange Registry examinations being performed will impact on the VA's ability to provide adequate routine outpatient care.

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Question 10. How many physician assistants and nurse practitioners are assigned to VA outpatient clinics?

Answer 10. As of March 31, 1982, the VA employed 478 physician assistants and 516 nurse practitioners. Our regular reporting system does not provide a breakout as to the specific area within the hospital where these individuals are working. A special Central Office Nursing Service study was conducted in April of 1980 which showed that 303 nurse practitioners were assigned to ambulatory care. Since the VA employed 475 nurse practitioners at the time of the study, 64% of them were working in ambulatory care. If you assume that this percentage has held constant, then approximately 330 of our current 516 nurse practitioners would be assigned to ambulatory care. No similar study has ever been conducted by Central Office for physician assistants.

Question 11A(i). In what ways and to what extent is automated data processing being used in conjunction with outpatient care?

Answer 11A(i). ADP Systems supporting the Outpatient Care area include:

I. The Outpatient Staff System (OPS) which provides on a sample basis the type of care provided to and demographic data on the using Veteran.

II. The Outpatient Fee System (OPF) which provides demographic data on and the type of care provided to the Veteran as well as processing the Health Care Provider's bill.

III. The Outpatient Scheduling System (OPSch) provides at certain Medical Care Facilities the input to OPS as well as the various tasks required to schedule patients at the various clinics.

IV. The Outpatient Segment of the Automated Management Information System (OS-AMIS) provides data on the type of care received by the Veteran.

V. The OPS, OPF, OS-AMIS and other Systems, all on a sample basis, provide the input to the Patient Care System (PCS) which contains on a longitudinal basis, data collected on the veterans medical care at VA Health Care Facilities (HCF).

These systems provide the data used to ascertain and project the number and type of veterans using the VA Outpatient System. Concomitantly, these systems provide the data used in management decisions concerning, among others, staffing requirements, facility location, and budget projections.

Question 11A(ii). Please describe the results.

Answer 11A(ii). The data provided by these systems is used on a daily basis to provide management with data required to operate the VA Outpatient Care System.

Question 11B(i). What plans are there for increasing this use of ADP?

Answer 11B(i). The OPSch System is scheduled to be expanded in the near future to many more HCF's. The OPS and OS-AMIS Systems are currently being modified in order to collect data on Veterans who claim Agent Orange or Radiation exposure.

Question 11B(ii). Please describe the expected results.

Answer 11B(ii). The change to OPSch will provide Automated Scheduling for HCFs that currently spend personnel time to manually maintain the Outpatient Clinic schedules.

Question 12A. To what extent do you believe the aging veteran population will create an increased demand in the next ten years for (i) outpatient, (ii) acute inpatient, and (iii) extended care?

Answer 12A. I believe the aging veteran population will create significant increased demand in all three areas. Determinations of the magnitude of needed adjustments will be based upon the Medical District Initiated Program Planning Process.

Question 12B. In your view, in which of these categories of care will the greatest burden of the health care needs of this population fall?

Answer 12B. Although substantial increases for patients age 65 and over are projected for all of the programs identified in Part A, the one which will have by far the greatest impact on the VA in terms of resources required will be the increased hospital workload.

Question 13A. How many outpatient visits system-wide in FY 1982 is the VA budgeted to provide?

Answer 13A. 16,129,000 staff medical outpatient visits.

Question 13B. How many outpatient visits per year was the VA budgeted for in each of the five prior fiscal years and how many visits were actually provided in each such year?

Answer 13B. Budgeted and actual staff medical outpatient visits for the past five years are as follows:

	Budgeted	Actual
FY 77	13,218,000	14,675,284
FY 78	14,725,000	15,069,573
FY 79	15,165,000	15,053,332
FY 80	15,165,000	15,751,690
FY 81	15,706,000	15,825,064

Question 13C. Please describe how an outpatient visit is defined for purposes of these statistics and comment on the extent to which hospitals reporting these visits use a uniform definition.

Answer 13C. A veteran seen on an outpatient basis is counted for one outpatient visit on that day, regardless of whether he is seen one or more times and regardless of how many "clinic-stops" he makes. For example, an outpatient who is seen for X-rays, blood tests, and an EKG, all on the same day, would have three "clinic-stops" but only one outpatient visit. If he returns the following day for additional testing/treatment, this would be counted as a second outpatient visit. Detailed instructions for reporting outpatient visits are presented in VA administrative directives and are used by all VA facilities.

Question 14A.

In the August 1981 Health Systems Information Service report, entitled "Appropriate Placement of VA Hospital Inpatients," giving the results of the 1979 one-day "Patient Census," it was noted that analysis indicated that approximately 23 percent of all patients in VA hospitals on that day could have been outplaced to other health care settings within 24 hours if resources had been available. Of this percent, it was indicated that 43 percent (over 6,400 patients) could have been treated as outpatients if the resources were available.

Given the VA's authority to provide post-hospital outpatient care, including to non-service-connected veterans, on either a staff or fee basis, why was such care not considered to be available for this significant block of patients?

Question 14B.

Please provide the same type of data for each subsequent year as to which such patient census data are available and, if substantial numbers of inpatients could have been outplaced to outpatient care, please provide an explanation as to why they were not discharged to outpatient care.

Answers 14A and B.

A question similar to that of the 1979 Patient Census appeared on the 1981 Patient Census. The results showed that approximately 26 percent (versus 23% in 1979) of all patients in VA hospitals on that day could have been outplaced to other settings within 24 hours if resources had been available. Of these patients, over 40 percent could be treated as outpatients.

The reasons for not discharging these patients to outpatient care are numerous and complex. There is frequently patient and/or family resistance to discharge. There are a number of different services required for a patient's discharge. Some are medical in nature and other non-medical (e.g. social services and support systems). The 1981 Patient Census investigated 14 such services to determine whether or not these services were

needed after (i.e. upon) discharge from the hospital. For those patients, who are being discharged, the average number of services required for discharge was 2.3. For those individuals who could be discharged, but are not, the average number of services required upon discharge was double, 4.6. Services studied included basic subsistence (living quarters, food, transportation), activities of daily living (bathing, dressing, feeding, toilet care, etc.), meal, homemaking or household services, social or recreational services, employment related, continuing nursing service, part-time nursing service, rehabilitation therapies, remedial training, adaptive housing, and supportive devices and prothesis. Thus, there are many services of a non-medical nature that may not be available to a veteran. For example, lack of a family or home environment, or improper nourishment or the inability to care for oneself, may prohibit a patient from being discharged from a hospital. These "14" services are not available to all patients, especially non-service-connected veterans.

Question 15A. Do you believe the VA health-care system as it is presently structured is so balanced?

Answer 15A. The VA health care program currently permits the provision of outpatient care to veterans if such care would obviate the need for hospitalization. Also, authority exists for allowing pre-hospital care to prepare a veteran for a stay in a VA hospital as well as post-hospital care to follow up that treatment that is received while hospitalized.

Question 15B. What are the implications in terms of need for additional resources or reallocation of resources of trying to achieve or maintain an appropriate balance of services as the veteran population ages?

Answer 15B. In order to maintain the appropriate balance of services and to ensure resource funding at a level adequate to maintain this balance as the veteran population ages, the Department of Medicine and Surgery has established a decentralized, grass roots planning process known as Medical District Initiated Program Planning (MEDIPP). For Fiscal Year 85, the construction and operations budgets will be based upon the results of the first cycle of plans which are due into Central Office in November, 1982.

Question 16A. You note in your statement that you do not maintain data on the percentages of outpatient visits made by women veterans.

What would be entailed in starting now to collect such data?

Answer 16A. In order to establish a data base on outpatient visits made by women veterans, it would be necessary to modify the Outpatient Routing and Statistical Activity Record (our basic outpatient data collection form) and to modify our computer software package.

Question 16B. Will you do so?

Answer 16B. It would take approximately two or three years to obtain the necessary programming changes in our mainframe systems such as PTF, AMIS, and other various data collection and reporting systems in order to accumulate and report such statistical data accurately. It is possible to do a special one-time survey utilizing the Outpatient Routing and Statistical Activity Record, but this would only provide a 20% sample of the total outpatient visits and would not truly reflect the number of visits made by female veterans.

Question 17A. On page 9 of your statement, you mention that a resources adjustment to the VA budget was made at the time Public Law 96-151 was enacted in response to the view expressed by the Congress that the VA had the flexibility to curtail the use of over-the-counter medicines if it desired.

What changes in policy were made in order to tighten eligibility for over-the-counter medications and how was this communicated to the field (please provide copies of any such guidance)?

Answer 17A. No specific changes in policy regarding over-the-counter (OTC) drug dispensing were implemented by VA at that time. However, Circular 10-80-143, issued July 15, 1980, reviewed the total issue concerning the policy on the prescribing and use of medication (see attached). Section five specifically addresses OTC drug usage and dispensing. It advises field stations to develop their own methods to alter OTC dispensing in line with stated procedures on dispensing medications ordered by authorized physicians. "Legislation does not address the issue of limiting the dispensing of OTC medications to any veteran."

Question 17B. What was the amount of savings achieved by the adjustment?

Answer 17B. No data is available.

Question 17C. Are you satisfied that these policy changes have been followed by field facilities?

Answer 17C. Based on the numerous inquiries from field facilities concerning possible methods to limit over-the-counter medication dispensing, it is apparent that conscientious efforts are being undertaken by medical centers. During the early to mid 1970s, the rate of growth for all ambulatory prescriptions averaged 17% per year. From FY 77 through FY 81, the annual rate of growth for all VA ambulatory prescriptions was 6.04%. I assume that a portion of the decrease in prescription volume growth can be attributed to medical centers actively reviewing medication dispensing.

CIR 10-81-148
July 17, 1981

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE	SECURITY CLASSIFICATION
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FOR INFORMATION CALL		
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THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED (Use double spacing and all capital letters)

TO: DIRECTORS, ALVAMC AND REGIONAL OFFICES WITH OUTPATIENT CLINICS

00/DM&S CIRCULAR 10-81-148

SUBJ: EXTENSION OF DM&S CIRCULAR 10-80-143 DATED JULY 15, 1980, POLICY ON THE PRESCRIBING AND USE OF MEDICATION,

THE EXPIRATION DATE OF CIRCULAR 10-80-143 IS TO BE EXTENDED TO JULY 14, 1982. THIS CIRCULAR EXPIRES JULY 14, 1982. 119/10A

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Thomas Hagen
for
-W. J. Farrally, M.D.

PAGE NO.	NO. OF PGS.	SECURITY CLASSIFICATION
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Veterans Administration
Department of Medicine and Surgery
Washington, D.C. 20420

CIRCULAR 10-80-143
July 15, 1980

SUBJ: Policy on the Prescribing and Use of Medication

TO : Directors of VA Medical Centers, Medical and Regional Office Centers, Domiciliary, Outpatient Clinics and Regional Offices with Outpatient Clinics

1. This is a complete revision of expired DM&S Circular 10-74-44.

2. The purpose of this circular is to restate the DM&S policy on the prescribing and use of all drugs in our total patient care program and to designate responsibility for implementation of the policy.

3. Successful implementation of any policy is dependent upon guidance and direction from an authoritative source. This responsibility is delegated to the Chief of Staff.

4. To administer a sound drug policy properly, DM&S must re-emphasize the role of the Therapeutic Agents and Pharmacy Reviews Committee, the Executive Committee on Therapeutic Agents, the Chief of Pharmacy Service and their relationship to the Drug Utilization Review process.

a. Therapeutic Agents and Pharmacy Reviews Committee. This committee is an advisory group of medical staff coordinated with Pharmacy Service to provide the organizational line of communication to the administration of the VA Health Care Center on the use of drugs. The role of this Committee is re-emphasized to consider all matters related to the use of drugs in the health care center in providing optimum health care. The Committee should be concerned and provide a continuous audit in all drug-related areas leading to better teaching, better medical prescribing patterns and ultimately better health care delivery. Consideration must be given to cost and availability. The purchase of high cost drugs, when equally effective, but less expensive preparations are available, cannot be justified.

VA's long standing policy of not rigidly restricting professional practice by administrative direction is not changed. Our policy on the use and prescribing of drugs is stated in the following:

M-2, Part I, Chapter 3, outlines functions and responsibilities of the Therapeutic Agents and Pharmacy Reviews Committee. In general physicians and dentists will be encouraged to prescribe drugs by generic (official or nonproprietary) nomenclature. This will be applicable particularly to those drugs which are available from two or more manufacturers, or for which there are two or more recognized and acceptable brands under different trade names. This does not exclude the use of well-known brands, but provides for

generic nomenclature whenever practical to prevent unnecessary duplications and reduce the high drug cost when equally effective but less expensive preparations are available.

The VA has adopted the American Hospital Formulary Service as our agency-wide formulary. Each facility will be guided by M-2, Part VII. Changes will be reported to Veterans Administration Central Office Executive Committee on Therapeutic Agents (119) through submission of copies of the minutes from each local committee meeting on a monthly basis.

b. Drug Utilization Review: The Department of Medicine and Surgery established the Health Services Review Organization (HSRO) to evaluate the quality of health care delivery provided by DM&S. The development of the Systematic Internal Review (SIR) by every VA health care center should include definite program plans for Drug Utilization Review (DUR).

Surveillance of the total drug regimen of each patient is an important aspect in the quality of patient care. Drug Utilization Review (DUR) is a multidisciplinary team effort required of all members associated with health care delivery. The SIR program can benefit by using DUR to evaluate the current level of physician prescribing patterns and the patient drug consumption. Efforts such as DUR should be implemented to apprise and assure management that expenditures for pharmaceutical care are making the maximum possible contribution to health care delivery.

The focal point of Drug Utilization Review rests on those hospital committees important to drug control. The Therapeutic Agents and Pharmacy Reviews Committee and the Infection Control Committee serve as the primary data bank for drug usage, frequency of use of individual drugs and therapeutic categories, cost of medication regimens, and reporting of all adverse drug reactions and drug interactions. Clarification of the individual committee functions will assist in identifying various methods for providing controls.

The Drug Utilization Review functions may be assigned to a subcommittee or these same responsibilities may be assumed by the Therapeutic Agents and Pharmacy Reviews Committee. The Therapeutic Agents and Pharmacy Reviews Committee provides the basic mechanism for the development and implementation of DUR in lieu of a separate committee.

The Infection Control Committee composed of representatives from the medical, pharmacy, and nursing staffs, plus other appropriate services, is responsible for investigating, controlling and preventing infections within the medical center. This committee should contribute to the DUR Program by developing statistical information on the use of antibiotics, by monitoring their use and discussing the biopharmaceutical and pharmacological aspect of antibiotics.

The VA quality of care assessment and success of the Systematic Internal Review (SIR) will require a concerted effort by all concerned DM&S employees to actively become involved in all Drug Utilization Review Programs.

c. Executive Committee on Therapeutic Agents Will:

(1) Develop, recommend and disseminate information on safe, effective and rational use of drugs in accordance with the Chief Medical Director's policy.

(2) Review and monitor significant actions of Therapeutic Agents and Pharmacy Reviews Committee Meetings from medical centers to determine appropriateness of policies on drug usage and to identify and recommend needed changes.

(3) Conduct studies on drug utilization patterns for medical centers, review the actions of other committees in Central Office dealing with drugs.

(4) Review and act on requests from medical centers and clinics for use of drugs not available in interstate commerce and for which an FDA New Drug Application has not been effected, e.g., investigational drugs to be used in the care of a specific patient.

(5) Evaluate reports of Adverse Drug Reactions and Drug Interactions prior to forwarding them to FDA.

(6) Review and act on quality improvement reports submitted by VA medical centers and clinics which indicate dissatisfaction with the quality of drug products. Appropriate information will be coordinated with concerned officials of the Food and Drug Administration, United States Pharmacopeia and the National Formulary.

(7) Review proposed marketing actions on drug items; recommend appropriate action to Supply Service.

(8) Perform such other functions as may be assigned by the Chief Medical Director.

d. Chief, Pharmacy Service. The Chief, Pharmacy Service, with the advice and counsel of the Therapeutic Agents and Pharmacy Reviews Committee at each local facility is charged with the responsibility of providing the most effective, FDA approved, therapeutic agents and medical supplies available for use by the medical staff in treating each patient's need.

Pharmacy Service is to continue efforts for collection, assimilation, and reporting to the Therapeutic Agents and Pharmacy Reviews Committee. Specific actions can be taken by Pharmacy Service to accomplish the intended goals of drug utilization review. The intravenous admixture service (Total Parenteral Care) provided by Pharmacy should be reported monthly to the Committee on high cost items usage by drug and cost. A Pharmacy in those health care centers which provide for a unit dose dispensing service (Medication Management) will continue to report on the quality assessment of selected patient medication profiles. Each medication profile in the unit dose dispensing program should be reviewed daily by a pharmacist. A review by a pharmacist of the original physician's order in those facilities not providing unit dose dispensing is strongly encouraged. Weekly chart review by a pharmacist practitioner of the total medication regimen will serve as a meaningful method to provide DUR and report to the Therapeutic Agents and Pharmacy Reviews Committee of this assessment. All patient medication profile packets will be reviewed prior to dispensing drugs in the Ambulatory Care Program, and the Prescription Mail-In Program.

5. To clarify the status of over-the-counter drug usage and dispensing, veterans properly enrolled in an authorized outpatient program will be furnished required medications and supplies to which they are legally entitled, and which have been ordered by the responsible physician.

Within the intent of the above statement certain measures can be taken to alter prescribing patterns of Over-The-Counter drugs to the extent that usage is more consistent with need. These measures include:

a. Monitoring of prescribed medication regimens for selected drug items exceeding one year.

Too often when many drugs are prescribed it becomes routine to continually renew the prescription. After one year on these drugs, a review of need to continue may result in discontinuance and a cost savings.

b. In accordance with provision of M-2, Part VII, par. 4.02b(3), "As directed" or "prn" are not considered to be specific directions for use. When this occurs the pharmacist should consult with the prescribing physician to determine dosage and proper directions to cover authorized time period.

c. The Clinical Executive Board and/or the Therapeutic Agents and Pharmacy Reviews Committee should develop other options for meeting the stated intent. From the local perspective, an indepth and regular review of all drug dispensing practices can result in implementation of other measures to meet the stated goal.

6. Efforts to obtain cooperation by non-VA physicians to prescribe generically and in accordance with the local medical center formulary and the policy on "ineffective" or "possibly effective" drugs are being made with varying degrees of success. It is requested that each facility review their current policy in these activities, and where indicated, initiate a progressive program to advise non-VA physicians of our policies. There are several positive efforts that can be made.

Effective implementation of such a program will require that contacts with prescribers be done in a professionally accepted manner. Nothing can turn a prescriber away from a cooperative attitude faster than the feeling that his/her professional prerogatives are being jeopardized. Therefore, your contacts with non-VA physicians should be made by selected physicians or pharmacists who can diplomatically and professionally explain these policies and elicit the support of the non-VA prescriber. Written communications should be carefully worded to avoid the appearance of dictating prescribing policy, and should be signed by the Chief of Staff.

When prescriptions are received for drugs, pharmaceuticals, related medical supplies and appliances not stocked in Pharmacy Service, efforts should be made to obtain permission of the prescriber to dispense a

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therapeutically equivalent drug or a medically acceptable appliance, if he/she has not already given authority by means of the Prescription Form. It should be possible, therefore, to minimize or eliminate many of the dual inventories maintained in Pharmacy to accommodate non-VA physicians.

7. Under the function of assuring the quality of care being delivered at the facility, the Chief of Staff will provide the mechanism for the implementation, monitoring, and corrective action measures necessary to fulfill the intent of this policy.

W. J. JACOBY, JR., M.D.
Deputy Chief Medical Director

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Question 18. What actions could DM&S take to prevent or discourage a VA physician from prescribing " a more expensive legend drug" to take the place of an over-the-counter drug?

Answer 18. VA's assumption that a more expensive legend drug might be prescribed if over-the-counter (OTC) medications were not available was made in reference to those situations where an OTC medication is the drug of choice for treating a specific disease state. For example, using cimetidine, a legend drug, for ulcer therapy when an OTC antacid might be more appropriate, but not available for use because of legislation. Therefore, any action to prevent VA physicians from prescribing more expensive legend drugs would interfere with the physician's responsibility to practice medicine. It is not advisable to alter the practice of medicine by limiting the physician's therapeutic tools.

Question 19. On page 11 of your statement, you note that your proposed restructuring of the beneficiary travel program would diminish its annual cost by some $30.7 million for each of the first five years. In the budget documents submitted by the VA in support of the President's Fiscal Year 1983 budget, it was stated that the reductions in beneficiary travel would result in $24 million savings in FY 83. Please explain the discrepancy between the figures in your statement and the budget documents.

Answer 19. The $30.7 million figure is the most current estimate.

Chairman SIMPSON. Now the next panel. And there will be questions from other members of the committee also. Dr. Rodney Baker, Associate Chief of Staff for Ambulatory Care of the Veterans' Administration Medical Center in Little Rock; Dr. William Bickers, Associate Chief of Staff for Ambulatory Care of the Veterans' Hospital Medical Center in Memphis; and Dr. Gilbert Houston, Chief Medical Officer of the VA Outpatient Clinic in Fort Myers, Fla.

I appreciate your participation. If you would, proceed. Please try to observe the time constraint. I don't like to use this marvelous contraption and would rather not, but will, of course. Thank you.

If you would please proceed in the order, if you wish, as on the agenda.

TESTIMONY OF A PANEL CONSISTING OF DR. RODNEY C. BAKER, ASSOCIATE CHIEF OF STAFF FOR AMBULATORY CARE, VETERANS' ADMINISTRATION MEDICAL CENTER, LITTLE ROCK, ARK.; DR. WILLIAM J. BICKERS, ASSOCIATE CHIEF OF STAFF FOR AMBULATORY CARE, VETERANS' ADMINISTRATION MEDICAL CENTER, MEMPHIS, TENN.; AND DR. GILBERT HOUSTON, CHIEF MEDICAL OFFICER, VETERANS' ADMINISTRATION OUTPATIENT CLINIC, FORT MYERS, FLA.

Dr. BAKER. Mr. Chairman, I will condense in an effort to save time.

In the 1960's, the delivery of outpatient care was expanded to include followup care following hospitalization. This post-hospital care program was one of the multiple forces that led to the development in the larger and affiliated VA medical centers of the present subspecialty-oriented outpatient structure. In 1973, Public Law 93-82 established the ambulatory hospital care program. The non-service-connected veteran was now eligible for outpatient care to obviate the need for hospitalization.

These changes described above and other complex issues not described in entitlement to outpatient services have had the desired impact on the potential of the VA medical center and its staff and outpatient clinics to deliver services to the veteran in a more appropriate mode of delivery. However, the flexibility which this created, which is usually ideal for the professional staff and for the veteran consumer, has also created negative effects. The difficulty of allocating already limited resources to a rapid expansion of delivery of outpatient services is one of those. In Arkansas the increase was in excess of 25 percent in 1974 and 1975.

The lack of a sufficient management information system to plan and wisely manage outpatient operations is the second difficulty.

And the third is the competition among non-service-connected veterans for direct and immediate outpatient services which were previously only available to the veteran with service-connected disabilities, and who are still given priority to existing outpatient resources.

This latter problem seems to be a nonissue when the service-connected veteran is given clear priority, but the individual non-service-connected veteran with a chronic medical problem and very

limited personal resources can constitute an uncomfortable professional dilemma.

This background and the implied issues constitute the informal policy that concern us in planning, developing and managing our outpatient operations.

These services are largely delivered in specialty clinics by medical specialists that represent the broad spectrum of specialty practice in medicine, surgery, neurology, and psychiatry services. The clinics are supported adequately by a wide spectrum of personnel resources from psychology, nursing, dietetic, rehabilitation, social work, et cetera. Ancillary services, of course, are provided by laboratory, radiology and other ancillary services.

The insight into the veteran seeking care and who ultimately receives care is best gained by focusing on a medical center's admission or evaluation activity. At Little Rock, approximately 100 veterans per day are evaluated on a walk-in basis for need for care. Of these applicants, 70 percent are nonservice—are in the non-service-connected category and 30 percent have service-connected priority. By disposition, 40 percent of these veterans need services that by present definition require in-hospital services. Thirty percent have medical problems that require further diagnostic and/or treatment services that can be delivered utilizing outpatient facilities. Thirty percent require and/or desire only episodic or same day care, which in most instances we attempt to provide.

Of the veterans requiring further diagnostic and/or treatment services but not requiring hospitalization, demographic studies have been performed at the Little Rock VA that reveal the following composite of the usual veteran in this group:

He is about 60 to 61 years of age. He has two or more chronic medical problems. He is unemployed and commonly has permanent disabilities. He is unable to purchase community health services. He has a fragile, if not an unstable, social support, and the community in which he resides has a paucity of health resources to utilize. Another complex study of this nature has just been completed at the Durham VA also.

Outpatient management is the appropriate modality of care for this patient, and is probably the most cost effective. But the most important issue, which I wish to emphasize, is that the patient with chronic illness requires long-term care. The goal of health-care delivery for this veteran is to stabilize his illness or the disability resulting from its complications. Any adverse change in his health status increases the risk of dependency and thereby increases his risk for inpatient care. Equally pertinent is the adverse change in social supports. Collapse of the patient's social support system will result in dependency on institutional care when surrogate support cannot be found.

It is my thesis that the chronically ill or disabled or aging veteran requires a delivery system that provides long term care, and the delivery system should have as its foundation the provision of primary care services by multidisciplinary teams.

Several such models of care are now appearing in the spectrum of VA outpatient services. Care is usually delivered by teams composed of physicians, nurses in the expanded role, social workers, and rehabilitation specialists. Each professional's role impacts on

the patient's care so that the unique skills of each discipline creates a holistic approach to care. These clinic models are at present usually research or demonstration models, and are small in structure, and limited by design in their capacity to deliver care, but are cleanly demonstrating the direction of appropriate care for the population served.

More formalized programs such as hospital-based home care, the GREEC programs, and the broader based day treatment programs contain the same patterns of care.

The expansion of primary care services will require the maintenance of the subspecialty clinic structure that now presently exists. The efforts of primary care will hopefully make the consultant's role in the delivery of expert, disease-oriented consultation and care more efficient and effective. Many of the patients now followed by the specialty clinics can be followed by the primary care oriented staff.

In summary, I wish to reemphasize that it is the veteran in his sixth decade who is seeking care for chronic, incurable illness that has had considerable adverse impact on his health. Therefore, I have addressed the following issues:

Our need to provide cost-effective long-term care to meet the need of an aging population.

Second, I would like to remind you that legislation that impacts on current eligibility in a categorical manner but continues to include professional assessment of need creates a potential ethical dilemma for the health care professionals.

I direct your attention to the demonstrations of primary care in the VA, and at their capacity to deliver long-term services, while documenting the quality of care and its cost.

Fourth, I have attempted to justify expansion of resources for these modalities of care, but only after relatively subjective statements, of which this paper is representative, have been supported by objective results of cost-effectiveness research. In my opinion, the first priority and the best bet for high quality patient care in the VA in the future is an adequate health service research budget today. We are most willing to be able to submit our efforts to critical review and analysis.

Chairman SIMPSON. Thank you very much, doctor.

[The prepared statement of Dr. C. Rodney Baker, associate chief of staff for ambulatory care, Veterans' Administration Medical Center, Little Rock, Ark., and his responses to written questions submitted by Hon. Alan K. Simpson, chairman of the Senate Committee on Veterans' Affairs and Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs, follow:]

PREPARED STATEMENT OF DR. C. RODNEY BAKER, ASSOCIATE CHIEF OF STAFF FOR AMBULATORY CARE, VETERANS' ADMINISTRATION MEDICAL CENTER, LITTLE ROCK, ARK.

ISSUES IMPACTING VA OUTPATIENT OPERATIONS

ENTITLEMENT TO OUTPATIENT HEALTH CARE HAS BEEN GIVEN TO A PROGRESSIVELY LARGER VETERAN POPULATION OVER THE PAST 20 YEARS. DURING MY RESIDENT HOUSE STAFF EXPERIENCE IN THE LATE 1950S OUTPATIENT CARE WAS RESTRICTED TO THE DELIVERY OF SERVICES TO A VETERAN WITH "SERVICE CONNECTED" PROBLEMS AND DISABILITIES. IN THE 1960S, DELIVERY OF OUTPATIENT CARE WAS EXPANDED TO INCLUDE FOLLOW-UP CARE FOLLOWING HOSPITALIZATION (POST HOSPITAL CARE PROGRAM) FOR ALL VETERANS. THE PHC PROGRAM WAS ONE OF THE MULTIPLE FORCES THAT LED TO THE DEVELOPMENT IN THE LARGER, AFFILIATED VA MEDICAL CENTERS OF THE PRESENT SUB-SPECIALITY-ORIENTED OUTPATIENT STRUCTURE. IN 1973, PL93-82, ESTABLISHED THE AMBULATORY HOSPITAL CARE PROGRAM. THE NON-SERVICE CONNECTED WAS NOW ELIGIBLE FOR OUTPATIENT CARE TO OBVIATE THE NEED FOR HOSPITALIZATION.

THESE CHANGES DESCRIBED ABOVE (AND OTHER COMPLEX CHANGES NOT DESCRIBED) IN ENTITLEMENT TO OUTPATIENT SERVICES HAVE HAD THE DESIRED IMPACT ON THE POTENTIAL OF VA MEDICAL CENTERS AND OUTPATIENT CLINICS TO DELIVER SERVICES OF THE VETERAN TO A MORE APPROPRIATE MODE OF DELIVERING SERVICES. HOWEVER, WHILE THE FLEXIBILITY IS USUSALLY IDEAL FOR THE PROFESSIONAL STAFF AND THE VETERAN CONSUMER, IT HAS CREATED NEGATIVE EFFECTS:

1. THE DIFFICULTY OF ALLOCATING ALREADY LIMITED RESOURCES TO A RAPID EXPANSION OF DELIVERY OF OUTPATIENT SERVICES (INCREASES OF 20-25% IN 1974 AND 1975);

2. THE LACK OF A SUFFICIENT MANAGEMENT INFORMATION SYSTEM TO PLAN AND WISELY MANAGE OUTPATIENT OPERATIONS;

3. THE COMPETITION AMONG NON-SERVICE CONNECTED VETERANS FOR DIRECT AND IMMEDIATE OUTPATIENT SERVICES WHICH WERE PREVIOUSLY ONLY AVAILABLE TO THE VETERAN WITH SERVICE CONNECTED DISABILITIES, AND WHO ARE STILL GIVEN PRIORITY TO THE EXISTING OUTPATIENT RESOURCES.

THE LATTER PROBLEM SEEMS TO BE A NON-ISSUE WHEN THE SERVICE-CONNECTED VETERAN IS GIVEN CLEAR PRIORITY AS IN PL 94-531, BUT THE INDIVIDUAL NON-SERVICE CONNECTED VETERAN WITH A CHRONIC MEDICAL PROBLEM AND VERY LIMITED PERSONAL RESOURCES CAN CONSTITUTE AN UNCOMFORTABLE PROFESSIONAL DILEMMA.

OUTPATIENT STRUCTURE

THIS BACKGROUND AND THE IMPLIED ISSUES CONSTITUTE THE "INFORMAL POLICY" THAT CONCERN USE IN THE PLANNING, DEVELOPMENT, AND MANAGEMENT OF OUTPATIENT OPERATIONS.

THE LITTLE ROCK VA MEDICAL CENTER EXPERIENCED 160,714 OUTPATIENT VISITS IN FY 81, OF THESE VISITS

38.7% WERE DELIVERED TO SERVICE CONNECTED VETERANS.[1]

THESE SERVICES ARE LARGELY DELIVERED IN SPECIALTY CLINICS BY MEDICAL SUBSPECIALISTS THAT REPRESENT THE BROAD SPECTRUM OF SPECIALTY PRACTICE IN THE MEDICINE, SURGERY, NEUROLOGY AND PSYCHIATRY SERVICES. THE CLINICS ARE SUPPORTED BY A WIDE SPECTRUM OF PERSONNEL RESOURCES FROM PSYCHOLOGY, NURSING, DIETETIC, REHABILITATION, SOCIAL WORK, AND

OTHER SUPPORT SERVICES. ANCILLARY SERVICES ARE PROVIDED BY LABORATORY, RADIOLOGY, NUCLEAR MEDICINE SERVICES, AND OTHER ANCILLARY SERVICES.

THE VETERAN-POPULATION

INSIGHT INTO THE VETERAN SEEKING CARE AND WHO ULTIMATELY RECIEVES CARE IS BEST GAINED BY FOCUSING ON THE MEDICAL CENTER'S ADMISSION AND EVALUATION ACTIVITY. APPROXIMATELY 100 VETERANS PER DAY ARE EVALUATED FOR NEED FOR CARE. OF THESE "APPLICANTS" 70% ARE IN THE NON-SERVICE CONNECTED CATEGORIES AND 30% HAVE SERVICE CONNECTED PRIORITY. BY DISPOSITION, 40% OF THESE VETERANS NEED SERVICES THAT BY PRESENT DEFINITION REQUIRE IN-HOSPITAL SERVICES. 30% HAVE MEDICAL PROBLEMS THAT REQUIRE FURTHER DIAGNOSTIC AND/OR TREATMENT SERVICES THAT CAN BE DELIVERED UTILIZING OUTPATIENT FACILITIES. 30% REQUIRE AND/OR DESIRE ONLY EPISODIC OR "SAME DAY" CARE WHICH IN MOST INSTANCES WE ATTEMPT TO PROVIDE.

OF THE VETERANS REQUIRING FURTHER DIAGNOSTIC AND/OR TREATMENT SERVICES (BUT NOT REQUIRING HOSPITALIZATION), DEMOGRAPHIC STUDIES HAVE BEEN PERFORMED AT THE LITTLE ROCK VAMC[2] THAT REVEAL THE FOLLOWING "COMPOSITE OF THE USUAL VETERAN" IN THIS GROUP:

- HE IS 60-61 YEARS OF AGE
- HE HAS MORE THAN TWO CHRONIC MEDICAL PROBLEMS
- HE IS UNEMPLOYED (AND COMMONLY HAS PERMANENT DISABILITIES)
- HE IS UNABLE TO PURCHASE COMMUNITY HEALTH CARE SERVICES
- HE HAS FRAGILE IF NOT UNSTABLE SOCIAL SUPPORTS, AND THE COMMUNITY IN WHICH HE RESIDES HAS A PAUCITY OF HEALTH RESOURCES TO UTILIZE.[3] A COMPLEX STUDY OF THIS NATURE HAS JUST BEEN COMPLETED AT THE DURHAM MEDICAL CENTER.[4]

OUTPATIENT MANAGEMENT IS THE APPROPRIATE MODALITY OF CARE FOR THIS PATIENT, AND IS PROBABLY THE MOST COST EFFECTIVE. BUT THE MOST IMPORTANT ISSUE, WHICH I WISH TO EMPHASIZE, IS THAT THIS PATIENT WITH

CHRONIC ILLNESS REQUIRES LONG TERM CARE. THE GOAL OF HEALTH CARE DELIVERY FOR THIS VETERAN IS TO STABLIZE HIS ILLNESS OR THE DISABILITY RESULTING FROM THESE COMPLICATIONS. ANY ADVERSE CHANGE IN HIS HEALTH STATUS INCREASES THE RISK OF DEPENDENCY AND THEREBY INCREASES HIS RISK FOR INPATIENT CARE. EQUALLY PERTINENT IS AN ADVERSE CHANGE IN SOCIAL SUPPORTS. COLLAPSE OF THE PATIENT'S SOCIAL SUPPORT SYSTEM WILL RESULT IN DEPENDENCY ON INSTITUTIONALIZATION WHEN SURROGATE SUPPORT CANNOT BE FOUND.

DELIVERING LONG TERM CARE SERVICES:

IT IS MY THESIS THAT THE CHRONICALLY ILL OR DISABLED OR AGING VETERAN REQUIRES A DELIVERY SYSTEM THAT PROVIDES LONG TERM CARE, AND THE DELIVERY SYSTEM SHOULD HAVE AS ITS FOUNDATION THE PROVISION OF PRIMARY CARE SERVICES BY A MULTI-DISCIPLINARY TEAM.

THE DELIVERY OF PRIMARY CARE SERVICES HAS AS ITS GOAL THE ACHIVEMENT OF THESE ATTRIBUTES:[5]

1. ACCESSIBILITY-THE PROVIDERS OF CARE ARE ACCESSIBLE AND CHOOSE TO PARTICIPATE IN EFFORTS THAT MAKE SERVICES ACCESSIBLE TO THEIR PATIENTS AND CLIENTS;

2. COMPREHENSIVENESS-THE WILLINGNESS AND ABILITY OF PROVIDERS TO HANDLE THE GREAT MAJORITY OF THE COMMON HEALTH PROBLEMS OF ITS PATIENTS;

3. COORDINATION OF SERVICES-PROVIDERS COORDINATE ALL OF A PATIENT'S CARE, INCLUDING THAT CARE PROVIDED BY OTHER SPECIALISTS;

4. CONTINUITY OF SERVICES-THE PRIMARY CARE PROVIDER AND THE PROCESS OF CARE ENSURE CONTINUITY;

5. ACCOUNTABILITY-THE WILLINGNESS AND ABILITY OF THE PROVIDER TO REVIEW AND EVALUATE THE PROCESS OF CARE AND ITS OUTCOME.

WHILE NOT ALL OF THESE ATTRIBUTES ARE UNIQUE TO PRIMARY CARE, THEY ARE ALL ESSENTIAL TO IT.

SEVERAL SUCH "MODELS OF CARE" ARE NOW APPEARING IN THE SPECTRUM OF VA OUTPATIENT SERVICES.[6] CARE IS USUALLY DELIVERED BY TEAMS COMPOSED OF PHYSICIANS, NURSES IN THE EXPANDED ROLE, SOCIAL WORKERS, AND REHABILITATION SPECIALISTS. EACH PROFESSIONAL'S ROLE IMPACTS ON PATIENT CARE SO THAT THE UNIQUE SKILLS OF EACH DISCIPLINE CREATES A HOLISTIC APPROACH TO CARE. THESE CLINIC MODULES ARE AT THE PRESENT USUALLY RESEARCH OR DEMONSTRATION MODELS, AND ARE SMALL IN STRUCTURE, AND LIMITED BY DESIGN IN THEIR CAPACITY TO DELIVER CARE, BUT ARE CLEARLY DEMONSTRATING THE DIRECTION OF APPROPRIATE CARE FOR THE POPULATION SERVED.

MORE FORMALIZED PROGRAMS SUCH AS HOSPITAL BASED HOME CARE PROGRAM, GREEC PROGRAM, AND BROADER BASED DAY TREATMENT PROGRAMS CONTAIN THE SAME PATTERN OF CARE.

THE EXPANSION OF PRIMARY CARE SERVICES WILL REQUIRE THE MAINTENANCE OF THE SUB-SPECIALTY CLINIC STRUCTURE THAT NOW PRESENTLY EXISTS. THE EFFORTS OF PRIMARY CARE WILL HOPEFULLY MAKE THE CONSULTANT'S ROLE IN DELIVERY OF EXPERT, DISEASE-ORIENTED CONSULTATION AND CARE MORE EFFICIENT AND EFFECTIVE. MANY OF THESE PATIENTS NOW FOLLOWED BY THE SPECIALTY CLINICS CAN BE FOLLOWED BY PRIMARY CARE ORIENTED STAFF.

SUMMARY:

IN SUMMARY, I WISH TO RE-EMPHASIZE THAT IT IS THE VETERAN IN HIS SIXTH DECADE WHO IS SEEKING CARE FOR CHRONIC, INCURABLE ILLNESS THAT HAS HAD CONSIDERABLE ADVERSE IMPACT ON HIS HEALTH. THEREFORE, I HAVE ADDRESSED THE FOLLOWING ISSUES:

FIRST: OUR NEED TO PROVIDE COST-EFFECTIVE LONG TERM CARE TO MEET THE NEED OF AN AGING POPULATION.

SECOND: THAT LEGISLATION THAT IMPACTS ON CURRENT ELIGIBILITY IN A CATAGORICAL MANNER BUT CONTINUES TO INCLUDE PROFESSIONAL ASSESSMENT OF NEED CREATES A POTENTIAL ETHICAL DILEMMA FOR HEALTH CARE PROFESSIONALS.

THIRD: I DIRECT YOUR ATTENTION TO THE DEMONSTRATIONS OF PRIMARY CARE DELIVERY IN THE VA, AND AT THEIR CAPACITY TO DELIVER LONG TERM CARE SERVICES, WHILE DOCUMENTING THE QUALITY OF CARE AND ITS COST.

FOURTH: I HAVE ATTEMPTED TO JUSTIFY EXPANSION OF RESOURCES FOR THESE MODALITIES OF CARE, BUT ONLY AFTER RELATIVELY SUBJECTIVE STATEMENTS (OF WHICH THIS PAPER IS REPRESENTATIVE) HAVE BEEN SUPPORTED BY OBJECTIVE RESULTS OF COST-EFFECTIVENESS RESEARCH. IN MY OPINION, THE FIRST PRIORITY AND THE BEST BET FOR HIGH QUALITY PATIENT CARE IN THE VA IN THE FUTURE IS AN ADEQUATE HEALTH SERVICES RESEARCH BUDGET TODAY. WE ARE WILLING AND ABLE TO SUBMIT OUR EFFORTS TO CRITICAL REVIEW AND ANALYSIS.

BIBLIOGRAPHY:

1. UTILIZATION DATA
VA MEDICAL DISTRICT #19
NORTH LITTLE ROCK, ARKANSAS

2. C. RODNEY BAKER, M.D., AND JUDITH JAMESON, M.P.H., AMBULATORY CARE INFORMATION SYSTEM: EVALAUTION CLINIC SURVEY, VETERANS ADMINISTRATION MEDICAL CENTER, LITTLE ROCK, ARKANSAS 72206.

3. ARKANSAS STATE HEALTH PLAN, ARKANSAS HSAA HEALTH PLAN (1981) AND ARKANSAS STATE HEALTH DEPARTMENT OFFICE OF RURAL HEALTH, MR. ORSON BERRY.

4. JOHN R. FEUSSNER, M.D., CHIEF OF AMBULATORY CARE, AND W.E. COCKRELL III, M.P.H., VETERANS ADMINISTRATION MEDICAL CENTER, DURHAM, N.C.

5. MANPOWER POLICY FOR PRIMARY HEALTH CARE, INSTITUTE OF MEDICINE, NATIONAL ACADEMY OF SCIENCES, WASHINGTON, D. C., JUNE 1978.

6. JERRY CHARLES, M.D., ASSOCIATE CHIEF OF STAFF FOR AMBULATORY CARE, MEDICAL GROUP PRACTICE-DEMONSTRATION AND RESEARCH PROJECT, VETERANS ADMINISTRATION MEDICAL CENTER, SAN FRANCISCO, CALIFORNIA.

RESPONSE OF DR. C. RODNEY BAKER, ASSOCIATE CHIEF OF STAFF FOR AMBULATORY CARE, VETERANS' ADMINISTRATION MEDICAL CENTER, LITTLE ROCK, ARK., TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN K. SIMPSON, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1. If the Federal Government were to decrease its role in providing Medicare and Medicare Health Insurance, by continuing to implement higher deductibles and co-payments during the next 5-10 years, please comment on the impact such action would have on your VA outpatient workload.

Answer 1. The workload of the VA Medical Centers would increase. The chronically ill veteran with social security benefits plus VA pension has sufficient resources to disqualify him for Medicaid in Arkansas, but insufficient resources to purchase health care. The VA is usually his only resource-only his family has less resources.

Question 2. Please comment on the ability of the VA outpatient system to care for non-service-connected veterans with one or more chronic health problems. I am referring to those veterans who have chronic health-care problems but are unable to utilize or have exhausted other forms of community health-care resources.

Answer 2. These resources are limited. I have spoken in depth to this issue in my written testimony.

Question 3. Is the outpatient statutory priority system clearly understood by the VAMC administrative personnel who must implement its resources?

Answer 3. The Outpatient Statutory Priority System is clearly understood by administrative personnel.

Question 4. Please explain your screening process for potentially eligible veterans who seek outpatient health-care in your clinics.

Answer 4. The veteran who presents to make application for health care services is triaged immediately by specially trained and oriented nurses (supported by physician staff) according to health status:

a. Urgent or emergent-to be seen immediately by a physician or referred to emergency receiving;

b. priority-acutely ill, but not in pain or distress, and referred to a physician for evaluation in the order of arrival;

c. non priority-not acutely ill, but potentially requiring medical services. Referred to a physician by appointment or given same day appointment if available.

After physician's evaluation and plan is written, administrative and eligibility criteria are applied.

Question 5. Do the veterans generally understand the process and accept the restrictions?

Answer 5. Veterans do not generally understand the Outpatient Statutory Priority System. When needing or strongly desiring care for legitimate medical problems, they do not accept the restrictions easily.

Question 6. Does the clinic administrative staff find the process hard to interpret and implement?

Answer 5. Implementing a process that denies service is always difficult, particularly when the professional staff finds need for care, and limitation of resources necessitates prioritizing who receives care.

Question 7. If the present eligibility remains unchanged and increasing numbers of eligible aging veterans attempt to utilize the VA system, how will you further adapt your screening process?

Answer 7. Very little more can be done, other than carefully design the outpatient structure and continuously increase the efficiency of the care process.

Question 8. Please comment on how your clinic is reimbursed by the VA for the services it provides to veterans?

Answer 8. I am uninformed concerning the mechanism for funding Outpatient Operations-the specifics are centrally managed. The Management Information Systems are directed at large and gross issues.

Our hospital is given an allocation relating to numbers of visits experienced. The allocation is altered year by year in relationship to workload experience. Recently, workload experience (especially increase in workload) coupled with anticipated "level" budgeting has resulted in "non-rational" decrease in allocations.

I am of the opinion that considerable effort combined with creative incentives will be necessary if the outpatient operations are to be managed skillfully. The MEDIPP Program is our present hope.

Question 9. What will be the impact of growing eligibility on present staffing, resources and funding of your outpatient clinic?

Answer 9. A bed-based hospital system can adapt only so far. Some aspect must be given: "new" funding for a "new" mission or reallocation of present resources (devoted to inpatient care) to more cost effective outpatient care (if in truth it is more costly for the elderly and a population distributed somewhat widely geographically). (I am not trying to dodge the issues: the answers will require scholarly effort.)

Question 10. Do veterans in different geographic areas receive different levels of care, in terms of beneficary travel, over-the-counter drugs, dental care, etc?

Answer 10. It is my considered answer that the VA does make every attempt to give equal opportunity through its beneficiary travel and fee basis programs. But the veteran living near the VA Medical Centers undoubtedly is best served.

In consideration of veterans served by the Little Rock Medical Center vs those served by Hines in Chicago vs those served in El Paso, Texas Clinic-yes there may be differences-but the major difference that concerns me is the lack of alternatives to VA care in Arkansas as opposed to Chicago, etc.

Question 11. What efforts, including programmatic innovations and studies, are being made to ensure that high quality medical care continues to be provided at VAMC outpatient clinics, given increased numbers of eligible veterans and decreased resources?

Answer 11. Carefully designed programs such as Hospital Based Home Care, Psychiatric Day Hospital, Day Treatment Programs, Outpatient Surgery, Mobile Clinics, satellite clinics, etc., are operational and have varying formal evaluation to address proficiency, quality of cost. Some are operational using experimental design to answer outcome and impact questions. Health Service Research and Development is grossly underfunded, but the VA is a "natural" as a system to study the outcome of patient care.

Question 12. Do any of you have a problem of conflicting demands between your academic and clinician responsibilities, as outpatient physicians within affiliated VAMC?

Answer 12. I personally have no conflicts.

Question 13. We have heard you all comment on the competition among service-connected and non-service-connected veterans for outpatient VA health care. What further steps should be taken to change this popular notion that non-service-connected veterans are eligible for unlimited health-care?

Answer 13. The veteran should be carefully informed - hopefully prior to a health crisis. The veteran consumer should participate in the educational process provided a uniform policy can be stated and understood. Grievance should be handled as much as possible by concerned, third party. Congressional and VA Administration should be continuously aware of policy impact.

Question 14. Do you have specific suggestions to improve the management system in your hospitals, so that the outpatient programs could be run more effectively?

Answer 14. Constant surveillance of the needs (as opposed to wishes, if possible) of the veteran making application for care.

Detailed description of the outpatient structure.

Assessment of the present structure (who is receiving care; who delivers care; what resources are consumed; what is the cost of care; what is the outcome of care) and its capability to deliver the care needed.

Subsequent change if necessary to improve care or the efficiency of its delivery.

Outside and independant consultation may be necessary to implement change, because the above assumes a management and professional staff that agree on goals and specific objectives.

FIVE QUESTIONS REGARDING YOUR "PRIMARY CARE SERVICE MODEL"

Question 15A. Is it cost-effective in light of the fact that the VA Health-Care System will continue to remain within budgetary constraints in the coming fiscal years?

Answer 15A. We should wait for Dr. Jerry Charles to publish his studies--they have been accepted for publication in the near future. If the primary care models are cost effective they are most likely a solution to the budgetary constraints.

Question 15B. Does that model adequately serve the health-care needs of service-connected veterans, the population which the VA originally mandated by Congress to serve?

Answer 15B. Primary Care is as effective for the chronically ill service-connected veteran as the non-service-connected veteran.

The Primary Care Clinic in Little Rock was established to evaluate the chronically ill veteran (in 1973) who did not require immediate hospitalization. More non-service-connected veterans than service-connected veterans were originally seen in the Primary Care Clinic, because more non-service-connected than service-connected veterans presented seeking care. The needs, however, are similar.

Question 15C. Are the average aging veterans, with chronic illnesses you describe in your testimony, non-service-connected for the most part?

Answer 15C. As described above more non-service-connected than service-connected present making application for care. Because of restriction on long term care, only the service-connected veteran can be assured long term management.

Question 15D. Would such primary outpatient care models be necessary if Congress were to limit non-service-connected health-care eligibility?

Answer 15D. If the Department of Medicine and Surgery is to be a total health care system for a population that is disabled, chronically ill and aging, it requires primary care delivery. The only question quantity.

RESPONSE OF DR. C. RODNEY BAKER, ASSOCIATE CHIEF OF STAFF FOR AMBULATORY CARE, VETERANS' ADMINISTRATION MEDICAL CENTER, LITTLE ROCK, ARK., TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN CRANSTON, RANKING MINORITY MEMBER OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1A. Please describe the process whereby a veteran is determined to be eligible for outpatient care at your facility.

Answer 1A. Request for outpatient care is made by the veteran, by a physician or other representative in his behalf on VA Form 10-10, Application for Medical Benefits, or by letter or telephone.

Question 1B. Who makes this determination, and how and by whom is the veteran advised of an adverse determination:

Answer 1B. Determination of legal eligibility will be made on the basis of information contained in previously established administrative folder or claims folder located at appropriate VA Regional Office. If veteran is ineligible for outpatient care, he is advised of this determination while at the medical center or by individual letter with an adequate explanation over the signature of the appropriate staff person.

Question 1C. Please provide a copy of all written guidance issued at your facility relating to this determination.

Answer 1C. M-1, Part 1, Chapter 16

Question 1D. What efforts are made to advise veterans of the outpatient care eligibility criteria?

Answer 1D. Veterans are advised of outpatient care eligibility criteria by individual counseling, by use of VA pamphlets located in patient reception areas, by selected administrative personnel

attending service organization meetings, annual training conferences, or by letter at his request.

Question 2A. Who in your facility makes the determination that a veteran is eligible for fee-basis care?

Answer 2 A. Eligibility clerk updates medical record to determine legal entitlement. A physician serving as the professional coordinator for Fee Services reviews medical record and recommendations from private physicians to determine need.

Question 2B. To what extent is this determination thereafter reviewed or monitored by a physician?

Answer 2B. Physician review is made when a request to exceed monthly limitation is received or when an invoice is received for payment that exceeds $55 limit of program. In addition, all fee authorizations are reviewed as validity date expires:

One year for veterans less than 50% service-connected;

Three years for veterans 50% service-connected or more; and

In receipt of A&A (Aid and Attendance) or are World War I veterans.

Question 3. When a patient requiring post-hospital care is determined to be eligible for fee-basis care --

Question 3(i). what, if any contact do VA physicians make with the fee-basis physician?

Answer 3(i). Patient requiring post-hospital care that is eligible for fee basis is referred to the private physician of his choice. A copy of the hospital summary is forwarded by VA Medical Records

Section. Veteran is provided a letter of authorization, as well as an ID card, VA Form 10-1174, listing his entitlement.

Question 3(ii). what instructions or specifications as to the nature of fee basis care authorized does a VA physician provide?

Answer 3(ii). Fee basis authorization for a limited period of time or for a specific disability is sent to the fee basis doctor outlining authorized treatment, cost, and duration of care, with a copy to veteran.

Question 4. What criteria are followed in determining eligibility for each category of patients referred for fee basis care?

Answer 4. M-1, Part I, Chapter 18, paragraph 18.03 sets criteria for determining eligibility for all categories of care.

Question 5. In terms of numbers of patients, dollars expended on the care, and episodes of care, what amount of fee-basis care is provided in each category for which it is authorized?

Answer 5.

	Percentage of Visits	Costs	Percentage of Total Cost
C&P	4	$ 59,698	5
OP-SC	71	817,408	66
10-10	0	40	
OPT-NSC	3	106,150	9
A&A, UWI	18	212,314	17
Miscellaneous	4	44,852	3
		$1,204,462	

(Projected FY 82 (RCS 10-69) May Fee Management Report)

Question 6A. At your facility is referring patients to other VA and U.S. Government facilities accessible to the veteran considered before arranging fee-basis care?

Answer 6A. Referrals are made to other VA Medical Centers if the veteran lives within the catchment area boundaries of that medical center. Retirees are also referred to the Little Rock Air Force Base at Jacksonville, Arkansas.

Question 6B. Please provide copies of any current written guidance issued at your facility relating to consideration of such referrals.

Answer 6B. I have none.

Question 6C. Approximately how many patients per year are referred to such facilities?

Answer 6C. I have no record of the number of referrals; most of the referrals are made to Fayetteville and Memphis VA Medical Centers. I would estimate 60 per year to Fayetteville and 24 per year to Memphis.

Question 7A. In the area served by your facility, where would veterans matching the patient profile you described in your testimony seek care if they were denied care at the VA?

Answer 7A. Combined with answer b. below.

Question 7B. How would such non-VA care be paid for?

Answer 7B. The sources are few to nonexistent. The veteran receiving Social Security disability and pension is usually not eligible for Medicaid in Arkansas. The University of Arkansas

for Medical Sciences, the East End Clinic in Little Rock, and three Public Health Service Clinics in Arkansas will see patients in reference to ability to pay, but, again, are supported largely by third-party resources. Otherwise, the veteran is dependent on the private sector to deliver care without a source of payment.

Question 7C. What efforts are made at your facility to assist these veterans in locating alternative sources of care?

Answer 7C. During regular duty hours, two to three social workers counsel veterans individually, attempting to find sources of care.

Question 8A. Please provide for each of fiscal years 1979, 1980, and 1981, the number of outpatient visits budgeted at your facility, the demand for such care, and the number of visits actually provided.

Question 8B. How many outpatient visits is your facility budgeted for in fiscal year 1982 and is the number of outpatient visits made to date consistent with this level?

Question 8C. How many outpatient visits does your facility's budget provide for in fiscal year 1983, and what do you project as the demand for such care?

Answers 8A, B, and C.

	FY-79	FY-80	FY-81	FY-82	FY-83
Staff OP Visits Budgeted	163,795	163,795	163,795	163,795	163,795
Staff OP Visits Actual	167,235	160,433	164,623	*	*
Fee OP Visits Budgeted	40,883	39,105	38,066	42,634	45,230
Fee OP Visits Actual	39,280	40,029	42,100	*	

*FY-82 Staff - we are on target.
FY-82 Fee - we are a little over.

Chairman SIMPSON. Now, Dr. Bickers, please.

Dr. BICKERS. Mr. Chairman, I am pleased to be here today to discuss ambulatory care in the VA health-care system with you. Ambulatory care can provide an increased quality of care. It can do this only when it is at the center of whatever health-care delivery system it is a part of and not tacked onto inpatient care as has been done in the Veterans' Administration system.

This add-on philosophy regarding ambulatory care has resulted in episodic and inferior care. In addition, ambulatory care when compared to inpatient care can be cost effective. One has only to look at the daily cost of a hospital bed as compared to the cost of an ambulatory care visit to gain appreciation of this.

Ambulatory care in the Veterans' Administration health-care system has undergone phenomenal growth since it was extended to the non-service-connected veteran under Public Law 93-82 effected in 1973. For example, approximately 77,000 veterans non-service-connected received ambulatory care in fiscal year 1972 in the Memphis VA Medical Center, as compared to 155,000 in 1981.

Presently, there are a number of problems encountered in delivering ambulatory care within the VA system. The following, in my opinion, represent the major problems that impact daily upon the care rendered and effects not only the non-service-connected veteran but the health-care delivery as well.

Ambulatory care in the Veterans' Administration health-care system is determined by legislation and consequently subject to political influence. This influence should not encompass health-care delivery to the veteran who has given himself in defense of the honor of the country, but rather, ambulatory care legislation should be based upon careful definition of the veteran population to be served, the needs of that population with an eye for cost efficiency, and the resources that can be allocated for that care.

The outpatient eligibility priority system confounds these issues. We can serve a broader population but only through a piecemeal approach to that population. We can serve acute problems but not chronic ones. We can treat broken arms but not teeth.

Presently, the non-service-connected veteran composes 60 to 80 percent of the patients receiving care in VA medical centers. The majority of the NSC veterans are 64 years old, are below the national standard for poverty, unemployed, and look to the VA for all their health care. They have approximately 2.5 incurable diseases, take approximately 3.5 medications on a chronic basis, and cannot afford the transportation necessary to get their treatment or medications.

In addition, 26 percent of the veteran population presently utilizing the VA system is 65 years of age or older. By the year 2000 this will increase to 59 percent. This will mean more poverty, more unemployment, more incurable diseases, and unless there is a drastic change in our national health-care system, less ability to receive care outside the VA system.

Adequate resources have not been provided by way of the per diem method for ambulatory care. This has prompted the institution of certain controls upon the ambulatory medical care. These controls have taken the form of staying within an annually assigned number of ambulatory care visit. The number of annual

visits is maintained by giving the non-service-connected veteran a fixed period of outpatient care after hospitalization. After this defined period, a determination is made medically concerning the veteran's condition. If his condition is stable—which is not to be confused with cured—he is discharged to seek care from some other resource.

In the Memphis VA Medical Center's catchment area, these resources are sparse to the point of being almost nonexistent.

For example, a non-service-connected veteran patient is hospitalized for heart failure and high blood pressure. Both are very common—high blood pressure afflicts at least 10 percent of the adult U.S. population—and both conditions can be considered in many instances stable and after 3 months, 6 months, or 1 year the patient is discharged from ambulatory care. Most NSC veterans so discharged will have their condition worsen, resulting in a marked decrease in the quality of life.

They will reapply to the VA, and if admitted to the hospital, will start the process all over again. The other possibility is that they might die of their condition prior to returning. For the NSC veteran, we serve his acute condition if he gets to us soon enough, his primary condition as this year's law allows, and his chronic condition only if following its acute stage.

The NSC veteran is afflicted with incurable and chronic diseases. These diseases can only be cared for by means of careful long-term management. The VA system has been allocated resources to provide only episodic crisis care to this group, whereas the aging NSC veteran requires continuous care. This is the cornerstone of chronic disease management, and without this cornerstone quality and quantity of life suffers.

Additionally, cost of care is not effectively maintained. Given adequate maintenance and support, the chronic conditions of our aging NSC population can be controlled and the acute exacerbation of these diseases minimized. We can keep people in their own homes, living their own lives independently without displacing lives to the premature care of long-term inpatient facilities.

Thank you.

Chairman SIMPSON. Thank you very much, Doctor.

[The prepared statement of Dr. William J. Bickers, Associate Chief of Staff for Ambulatory Care, Veterans' Administration Medical Center, Memphis, Tenn., and his responses to written questions submitted by Hon. Alan K. Simpson, chairman of the Senate Committee on Veterans' Affairs, and Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs, follow:]

PREPARED STATEMENT OF DR. WILLIAM J. BICKERS, ASSOCIATE CHIEF OF STAFF FOR AMBULATORY CARE, VETERANS' ADMINISTRATION MEDICAL CENTER, MEMPHIS, TENN.

Prior to 1973, the Veterans Administration health care system provided limited ambulatory health care services. Legislation enacted in 1973 authorized ambulatory care to nonservice-connected veterans, and provided for the first time the possibility of giving continuity of care to a majority of nonservice-connected veterans in a cost-effective and compassionate manner.

Ambulatory Care can provide an increased quality of care. In addition, ambulatory care when compared to inpatient care, can be cost-effective. One has only to look at the daily cost of a hospital bed as compared to the cost of an ambulatory care visit to gain appreciation of this. Ambulatory Care in the Veterans Administration health care system has undergone phenomenal growth since it was extended to nonservice-connected veterans under Public Law 93-82 effected in 1973. For example, 77,021 veterans received ambulatory care in FY 72 in the Memphis VA Medical Center as compared to 155,649 in 1981.

Presently, there are a number of problems encountered in deliverying ambulatory care within the VA system. In the Memphis VA Medical Center, we see 160,000 veterans

annually. The following, in my opinion, represents the major problems that impact daily upon the care rendered, and affects not only the nonservice-connected veterans but the health care deliverers as well. In addition, examples of how these problems increasingly affect patients are provided.

I. Determinants of Ambulatory Care.

Ambulatory Care in the Veterans Administration health care system has been determined by legislation enacted over a period of years and does not provide for comprehensive services. Ambulatory care should be based upon careful definition of the veteran population to be served, the needs of that population with an eye for cost efficiency and the resources that can be allocated for that care. The outpatient eligibility priority system confounds these issues: we can serve a broader population but only through a piecemeal approach to that population; we can serve acute problems but not chronic ones.

Presently, the nonservice-connected veteran composes 60-80 percent of the patients receiving care in VA medical centers. The majority of the nonservice-connected veterans are 64 years old, are below the national standard for poverty, unemployed, and look to the VA for <u>all</u> their health care. In addition, they have approximately 2.5 incurable diseases, take approximately 3.5 medications and cannot afford the transportation necessary to get their treatment or medications.

It would not only seem reasonable but necessary that these characteristics are considered in designing an ambulatory care program. Aging projection of the veteran

population is of increasing importance. For example, 26 percent of the veteran population presently utilizing the VA system is 65 years or older. By 2000 A.D., this will increase to 59 percent. This will mean more poverty, more unemployment, more incurable diseases, and, unless there is a drastic change in our national health care system, less ability to receive care outside of the VA system.

2. Ambulatory Care Resources Funding.

Adequate resources have not been provided to meet all the demand for ambulatory care. This has prompted the institution of certain controls upon ambulatory medical care to stay within an annually-assigned number of ambulatory care visits. The number of annual visits is maintained by giving the nonservice-connected veteran a fixed period of outpatient care after hospitalization. After this defined period, a determination is made medically concerning whether the veteran's condition was stable or not. If his condition was stable (not to be confused with cured), he was discharged to seek care from some other resource. In the Memphis VA Medical Center's catchment area, these resources are very sparse to the point of being nonexistent.

For example, a nonservice-connected veteran is hospitalized for heart failure and high blood pressure. Both are very common (high blood pressure afflicts at least 10 percent of adult U.S. population) and both conditions can be considered in many instances "stable" and after three months, six months, or a year, the patient is discharged. This veteran patient's alternatives are to obtain care elsewhere. The rest will have their condition worsen, resulting in a marked decrease in quality of life. They will reapply to the VA and if admitted to the hospital will start the process all over again. The other

possibility is that they might die of their condition prior to returning. For the nonservice-connected veteran, we service his acute condition if he gets to us soon enough, his primary condition as this year's law allows, and his chronic condition only if following its acute stage. Other common medical conditions such as diabetes mellitus, arthritis, renal failure, or chronic obstructive lung disease could just as easily be used as examples.

3. Episodic Care for Long-Term Needs.

The nonservice-connected veteran is afflicted with incurable and chronic diseases. These diseases can only be cared for by means of careful long-term management. The VA system has been allocated resources to provide only episodic crisis care to this group whereas the aging nonservice-connected veteran requires continuity of care. This is the cornerstone of chronic disease management, and without this cornerstone quality and quantity of life suffer. In addition, cost of care is not effectively maintained. Given adequate maintenance and support, the chronic conditions of our aging nonservice-connected population can be centralized and the acute exacerbation of these diseases minimized. We can keep people in their own homes, living their own lives independently without displacing lives to the premature care of long-term inpatient facilities.

Mr. Chairman, that concludes my remarks. I will be happy to respond to any questions that you or the committee may have.

RESPONSE OF DR. WILLIAM J. BICKERS, ASSOCIATE CHIEF OF STAFF FOR AMBULATORY CARE, VETERANS' ADMINISTRATION MEDICAL CENTER, MEMPHIS, TENN., TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN K. SIMPSON, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

QUESTION 1. If the Federal Government were to decrease its role in providing Medicare and Medicaid health insurance by continuing to implement higher deductibles and co-payments during the next 5 to 10 years, please comment on the impact such action would have on your VA outpatient workload.

ANSWER 1. We have no statistics on such changes impacting on outpatient delivery thus far. In discussions with our staff, changes in Medicaid eligibility have had little if any impact. Changes in Medicare deductible and co-payments have paralleled the timing of our own NSC eligibility laws hence making cause and effect conclusions difficult to estimate. Suggestive are those instances of major catastrophic illness for the Medicare eligible veteran who seeks VA assistance for the first time via his/her private physician or private hospital referral.

QUESTION 2. Please comment on the ability of the VA outpatient system to care for non-service-connected veterans with one or more chronic health problems. I am referring to those veterans who have chronic health-care problems but are unable to utilize or have exhausted other forms of community health-care resources.

ANSWER 2. If the NSC veteran is neither eligible for Housebound or Aid and Attendance benefits nor appropriate for one of the special categories of need (spinal cord injury, blind, substance dependence, etc.) we would follow him/her for no more than one year normally. A veteran so discharged from care can and does reapply for acute exacerbations of a chronic condition and followed for that stage of treatment. Locally we would follow each acute episode with ever more abbreviated lengths of outpatient treatment. Thus, we do not provide continuous medical management of chronic conditions for the NSC veteran.

Question 3. Is the outpatient statutory priority system clearly understood by the VAMC administrative personnel who must implement its restrictions?

ANSWER 3. It is understood by Memphis VAMC administrative personnel.

QUESTION 4. Please explain your screening process for potentially eligible veterans who seek outpatient health-care in your clinics.

ANSWER 4. I am not aware of a screening process for veterans seeking outpatient health care here. When a veteran applies for help with a medical complaint and is not admitted, he/she is either referred to one of our clinics or discharged as hospitalization-not-indicated. The decision to refer the veteran to one of our clinics is made by a health provider; the decision to discharge is always made by a physician.

QUESTION 5. Do the veterans generally understand the process and accept the restrictions?

ANSWER 5. Veterans generally understand the process after it is explained to them but their acceptance of its restrictions seem to be based on their personal expectations of care which are modified only moderately by our explanations.

QUESTION 6. Does the clinic administrative staff find the process hard to interpret and implement?

ANSWER 6 Administrative staff do not find this process hard to interpret and implement given sufficient time to establish protocols and procedures secondary to changes in administrative rulings and interpretations.

QUESTION 7. If the present eligibility remains unchanged and increasing numbers of eligible aging veterans attempt to utilize the VA system, how will you further adapt your screening process?

ANSWER 7. The screening process for those veterans seeking attention for their medical complaints will essentially remain unchanged. As clinics become filled and resources expended, more NSC veterans will be discharged as hospitalization-not-indicated without clinic referrals. For those veterans over the age of 65, we might include an obligatory referral to Social Work Service or the health benefits counselors to be certain all possible VA and community benefits are applied for before discharge.

QUESTION 8. Please comment on how your clinic is reimbursed by the VA for the services it provides to veterans?

ANSWER 8. The Hospital Director has some latitude as to how our hospital's resources will be allocated -- whether inpatient or outpatient oriented. Many of our hospital's resources in staff, technical expertise, equipment and even space are pooled and shared with inpatient and outpatient demands made on them. There is a cost accounting formula based on a nationwide figure which suggests a reimbursement of an all-inclusive, fee-per-patient-per-day in our outpatient clinics. The number of patients so reimbursed comes from a cumulative total of the previous year's patients such that if we fell significantly short of that total this year, our hospital's budget could be cut for the next year.

QUESTION 9. Do veterans in different geographic areas receive different levels of care, in terms of beneficiary travel, over-the-counter drugs, dental care, etc?

ANSWER 9. Beneficiary travel, OTC's, dental care, eyeglasses, other prosthetics are given to veterans on a somewhat equal basis across the regions of our country. There is a latitude in interpretations of administrative policies meeting budget, however, as you go from hospital to hospital. Based on a particular hospital's budgetary priorities, a veteran may indeed get more of these benefits at one hospital as compared to another.

QUESTION 10. What efforts, including programmatic innovations and studies, are being made to ensure that high quality medical care continues to be provided at VAMCS outpatient clinics, given increased numbers of eligible veterans and decreased resources?

ANSWER 10. There are no studies or programmatic innovations to my knowledge that have as their focus a high quality outpatient medical care product under conditions of increased demand and decreasing resources.

QUESTION 11. Do any of you have a problem of conflicting demands between your academic and clinician responsibilities, as outpatient physicians within affiliated VAMCs?

ANSWER 11. Ours is an affiliated VAMC. There have been few conflicting demands thus far and those that exist have to do with the time limitations each places on the other: time to do an adequate job as a clinician-administrator versus time to be available for rounds, instruction and preceptorship.

QUESTION 12. We have heard you all comment on the competition among service-connected and non-service-connected veterans for outpatient VA health care. What further steps should be taken to change this popular notion that non-service-connected veterans are eligible for unlimited health-care?

ANSWER 12. To the degree that non-service-connected veterans still believe themselves eligible for unlimited health-care, we are doing an adequate job locally in advancing a more realistic assessment to this population in our information bulletins, patient handouts, communiques with veteran's groups and organizations, etc. Nationally other avenues might be taken but that is not in our purview.

QUESTION 13. Do you have specific suggestions to improve the management system in your hospitals, so that the outpatient programs could be run more effectively?

ANSWER 13. Management at this hospital is well aware and supportive of a major suggestion that would improve our effectiveness -- that of a computer-based information, assessment and functional problem-solving system.

RESPONSE OF DR. WILLIAM J. BICKERS, ASSOCIATE CHIEF OF STAFF FOR AMBULATORY CARE, VETERANS' ADMINISTRATION MEDICAL CENTER, MEMPHIS, TENN., TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN CRANSTON, RANKING MINORITY MEMBER OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question:

1. A. Please describe the process whereby a veteran is determined to be eligible for outpatient care at your facility.

Answer:

1. A. Outpatient care is determined by professional medical judgment. If the veteran is non-service connected (NSC) for his/her medical problem, he/she may receive outpatient care through one of the following mechanisms:
   (1) Following hospitalization the NSC veteran can be placed in outpatient care for necessary follow-up for a period of one year following the hospitalization. This decision is made by the attending physician.
   (2) Evaluation for need of further care a patient may present himself for the evaluation or be referred by another physician.
   (3) Placed on ambulatory care for a predetermined period of time at the initial medical evaluation.

Question:

1. B. Who makes this determination, and how and by whom is the veteran advised of an adverse determination?

Answer:

1. B. The determination is made by physicians or medical health care professionals (e.g. physician's assistant, nurse, practitioner, etc.) under the supervision of a physician. The veteran is advised by these health professionals of all decisions regarding his care.

Question:

1. C. Please provide a copy of all written guidance issued at your facility relating to this determination.

Answer:

1. C. There is considerable administrative law and policy relating to medical determination and eligibility for outpatient medical care. At the basis of these in MI-Pt. 1 Chapter 4 (March 14, 1979) VA regulation is the paragraph 4,26 "Determination of Medical Need." Station Memo 136-6 (July 18, 1980) details Memphis VAMC's Admission Policy and certifies the six dispositions (3.C) a physician might choose for an applicant. One of these dispositions is the Ambulatory Care Outpatient Program which is detailed in Memo 136-60 (April 7, 1982). Attached to the letter is a handout given to the veteran when he is discharged form outpatient care (attachment A) outlining our reasoning for discharge and other resources. We also include a VA patient handbook: "Guide to Ambulatory Care" available in open public racks for veterans and their families throughout the waiting areas of our ER/Admissions/Clinics areas.

Question:

1. D. What efforts are made to advise veterans of the outpatient care eligibility criteria?

Answer:

1. D. All health care professionals who come in contact with the veteran are made aware of eligibility criteria and discuss this with the veteran (and family member) when possible. Besides the handout and patient Guidebooks we have large printed placards mounted on the walls of each of our exam-treatment rooms detailing our priority criteria as information and a reminder to the patients as well as our rotating medical residents. Medical Administrative

Service personnel are constantly available in the admissions area to seek out questions and problems veterans may have regarding outpatient care eligibility. Veteran service officers (two) and Social Work Service staff are also available to the admissions area with nearby offices to relate to these and other questions regarding veterans benefits, personal problems and community resources.

Question:
2. A. Who in your facility makes the determination that a veteran is eligible for fee-basis care?

Answer:
2. A. Memphis VAMC is not a clinic of jurisdiction for purposes of approving fee-basis care and therefore has no responsibility for operating a fee-basis program. The clinic of jurisdiction in Tennessee is Nashville, which does approve and also monitors such fee-basis care.

Question:
2. B. To what extent is this determination thereafter reviewed or monitored by a physician?

Answer:
2. B. Such monitoring falls under the jurisdiction of the VAMC Nashville.

Question:
3. When a patient requiring post-hospital care is determined to be eligible for fee-basis care --
(i) what, if any contact do VA physicians make with fee-basis physician?
(ii) what instructions or specifications as to the nature of fee basis care authorized does a VA physician provide?

Answer:
3. (i) & (ii) None other than that normally rendered a private community physician, i.e., a hospital discharge summary would be forwarded at the appropriate signing of a Release of Information from by the veteran wishing referral back to his private physician following a treatment period here.

Question:
4. What criteria are followed in determining eligibility for each category of patients referred for fee-basis care?

Answer:
4. See the answer to question 2. A. above.

Question:
5. In terms of numbers of patients, dollars expended on the care, and episodes of care, what amount of fee-basis care is provided in each category for which it is authorized?

Answer:
5. I do not know. I would not normally have access to that information.

Question:
6. At your facility is referring patients to other VA and U.S. Government facilities accessible to the veteran considered before arranging fee-basis care?

Answer:
6. We do not consider fee-basis first in our referrals. The criterion for referral is usually continuity of care. If the best medical care can be provided through referral to an already approved fee-basis arrangement with a private physician, then we would

promote that continuity of care. A veteran may choose to visit any VA Hospital he/she wishes, of course.

B/C questions to provide copies of any current written guidance issued at your facility relating to consideration of such referrals; and approximately how many patients per year are referred to such facilities? The answers are: we have no such information or guidelines.

Question:

7. A. In the area served by your facility, where would veterans matching the patient profile you described in your testimony seek care if they were denied care at the VA?

Answer:

7. A. Patients from the Memphis area would probably go to the City of Memphis (Shelby County) Hospital. Since our catchment area covers parts of five states a realistic answer would be the private hospital where they reside.

Question:

7. B. How would such non-VA care be paid for?

Answer:

7. B. Non-VA care for the profile described is predominantly paid for by State-County supplements to the health and welfare system where the veteran lives. Some of our NSC veterans have insurance but it is usually woefully inadequate to meet the need/demand of a catastrophic illness. I am saying then, that most of the veterans we see are medically indigent, they make less than $10,000/year, and have little or no major medical insurance or paid sick-leave benefits.

Question:

7. C. What efforts are made at your facility to assist these veterans in locating alternative sources of care?

Answer:

7. C. Any veteran may be referred to Social Work Service if he should request it or the physician deems it important to seek alternative sources of care. Nurses and physicians may refer patients to specific public clinics and hospitals given the appropriate medical condition. We find that many of our veterans have already been referred to these alternatives by a private physician before coming to the VA but seek us out because we are available and free. True, alternative sources of medical care for most of our veterans in the south are not available if a major problem exists.

Question:

8. A. Please provide for each of fiscal years 1979, 1980 and 1981 the number of outpatient visits budgeted for at your facility, the demand for such care, and the number of visits actually provided.

Answer:

8. A.

FY	Budgeted	Actual
1979	145,599	157,409
1980	150,358	163,005
1981	150,358	155,649

Question:

8. B. How many outpatient visits is your facility budgeted for in fiscal year 1982 and is the number of outpatient visits made to date consistent with this level?

Answer:

8. B. We are budgeted for/plan for 150,359 outpatient visits for FY1982. Given our present demand we will meet that number this fiscal year.

Question:

8. C. How many outpatient visits does your facility's budget provide for in fiscal year 1983, and what do you project as the demand for such care?

Answer:

8. C. Projected FY 1983 outpatient visits are 150,000. We will not know the budgeted outpatient visits for next fiscal year until perhaps September 1982.

Question:

9. In your opinion, given your observation that most non-service-connected veterans seeking care at VA facilities have few, if any, other health-care resources and your emphasis upon the value of continuity of care, would increased investment in and expanded eligibility for outpatient care for chronic conditions reduce the inpatient care required by these veterans by an amount sufficient to represent a cost-effective tradeoff?

Answer.

9. In my opinion, the short-term answer would be no; the long-term yes. Reductions in inpatient care would not be forthcoming until a funding mechanism could be established that would reward (fund) VA Hospitals for keeping veterans out of hospital beds rather than in them. Ambulatory Care should be funded to prevent hospitalization and control exacerbations of chronic conditions that eventually require acute inpatient care if no such ongoing care is provided. The major cost-effective HMO's of this country have set up various incentives for keeping their patients out of inpatient beds and/or reducing the number of days requiring hospitalization. The VA should do likewise; we could here at Memphis, I believe.

If resources were made available in Ambulatory Care to treat those with chronic conditions we now may are eligible for care, the cost-effective trade-off would not become apparent for several years. It would take a period of time to get the veterans with chronic conditions in our potential veteran population stabilized to any degree, and to prepare our system to prospectively act for stabilizing patients rather than reacting to acute crises episodes. VA system-wide changes would be required. No one VA Medical Center could do it alone.

Since our VA population, including the Memphis VAH's, is expected to double in the number of geriatric (over age 65) patients requesting VA medical care over the next 20 years, that group might be the one to focus on for systematic change. The geriatric NSC veteran given continuity of care could represent a cost-effective trade-off in preventing hospitalization through greater access to VA Ambulatory Care.

c. Members or former members of the Armed Forces retired for disability or in receipt of disability retirement pay who require hospitalization for the chronic diseases enumerated in VA Regulation 6046.2(B), who have entitlement to hospitalization under the laws governing the VA, but do not elect it as VA beneficiaries, may be furnished hospitalization by the VA. If regulations of the service from which retired provide for payment of subsistence by such retired personnel during hospitalization, the VA will also charge for subsistence. (See VA Regulation 6047(B)(2) for admission authority.) They may not be furnished transportation incident to hospitalization at the expense of the VA. The submission of an application for hospitalization by those retired persons who are eligible for hospitalization under laws governing the VA will be presumed to be an election to receive hospitalization from the VA unless the applicant, when eligible therefor, specifically indicates an election for hospitalization under VA Regulation 6047(B)(2).

4.24 RESPONSIBILITY FOR DETERMINATION OF ELIGIBILITY AND NEED FOR HOSPITAL OR DOMICILIARY CARE

While overall responsibility for providing hospital and domiciliary care is that of the health care facility Director, the specific responsibilities for establishing eligibility and need for hospital or domiciliary care will be delegated as follows:

a. Medical need for hospital or domiciliary care will be determined by a responsible physician of the VA assigned this function.

b. Eligibility will be determined by appropriate administrative personnel.

4.25 PRIORITIES FOR HOSPITAL AND DOMICILIARY CARE

(See VA Regulation 6049.)

4.26 DETERMINATION OF MEDICAL NEED

Medical need is determined by a VA physician on the basis of an examination or on the basis of information furnished on the medical certificate on the application. The physician will determine whether the applicant requires hospital or domiciliary care, sign his or her name in the space indicated, and date the entry. The physician will also classify the case as emergent, urgent or general as applicable and whether the applicant requires hospital or domiciliary care, sign his or her name in the space indicated, and date the entry. The physician will also classify the case as emergent, urgent or general as applicable and whether the applicant should be placed on PBC, ambulatory care to obviate the need for hospital care or the waiting list. The examining physician will indicate the type of service to which the patient will be admitted. Applicants who need inpatient care for chronic conditions will not be rejected because of character of illness, non-availability of a bed, education and research interests or other extraneous considerations.. All reasonable doubt as to medical need for hospital care will be resolved in favor of the applicant.

4.27 DETERMINATION OF ELIGIBILITY FOR HOSPITAL CARE

The eligibility procedure is divided into two phases, i.e., the determination of eligibility, and the verification of eligibility, as follows:

a. The determination of eligibility will be made on the basis of information furnished on the application by the applicant, or person acting for him or her. It requires use of reasonable judgment to reach a decision that the information supplied qualifies the applicant for admission under the appropriate subparagraph of VA regulations. This judgment will be based on the premise that the information was given with full awareness on the part of the applicant of the penalties for making a fraudulent claim. An inquiry may be

VETERANS ADMINISTRATION MEDICAL CENTER
Memphis, Tennessee 38104

Memorandum No. 136-6
July 18, 1980

SUBJ: MEDICAL CENTER ADMISSION POLICY

1. Purpose. This publication establishes policy and responsibility for the processing of applicants for admission to the medical center.

2. Policy. All employees involved in the admission of patients must recognize their role and responsibility in the admission process.

a. Every eligible veteran is entitled to receive an evaluation to determine the medical care he/she needs through the proper modality, whether it be bed care, ambulatory treatment, or nursing home care.

b. The necessary medical judgments required to implement the appropriate mode and timing of patient care must consider all needs of the veteran. The socio-economic status, the availability of home assistance, and the patient's pattern of life are among the elements for judgment in arriving at this decision.

c. When doubt exists concerning care to be rendered, the benefit of a doubt must be granted to the patient to insure his well-being. The patient's welfare supersedes any other consideration within the process.

d. Eligible applicants who are in need of hospital care will be admitted to the station at which application is made. If appropriate staff and facilities are not available at the admitting center, arrangements will be made for transfer to the appropriate medical center within the Medical District, or to the nearest VA Medical Center with staff and facilities suitable for the treatment or evaluation of the veteran's condition.

e. In some instances a patient may be referred by a private physician for admission to this medical center. If the admitting physician disagrees with the need for hospitalization, the referring physician will be provided a copy of clinical evaluation.

f. We must assume every applicant for care is a sick person, or perceives himself as sick. As such, he is anxious about what might happen to him when in the medical center. Efforts must be made to handle this anxiety and to make the applicant comfortable. All personnel must know their role in the admission procedure. The Chief, Medical Administration Service, will insure that interviewing and counseling of applicants is conducted with dignity and in private.

g. At times it may be necessary to lodge a veteran because of inclement weather or irregular transportation schedules. Applicants for hospitalization will be furnished lodging by Medical Administration Service personnel in accordance with Medical Center Memorandum 136-21.

3. Implementation.

a. Applicants for hospitalization will be promptly screened and their medical needs assessed. The admitting physician has the full and final authority to admit a patient when, in his opinion, hospitalization is required. Consultations may be requested to determine the need for hospitalization.

EXPIRES JULY 31, 1983

b. On any patient where admitting-primary care staff or medical center police feel there could be a potential security problem, the following step will be taken:

Notify security if not already in attendance for assistance to include escorting to Psychiatry Service for evaluation or admission.

c. The admitting physician will make one of the following dispositions for each patient on the day of examination:

(1) Admit
(2) Reject - Not in need of hospitalization
(3) Schedule applicant for admission at a future date
(4) Place on waiting list (if no appropriate bed is available)
(5) Place in Pre-bed Care Program
(6) Place in Ambulatory Health Care Program

d. If a patient was referred by a private physician and rejected as not in need of hospitalization, Medical Administration Service will secure patient consent for release of information. On the following workday, clinical findings along with a cover letter signed by the ACOS for Ambulatory Care will be mailed to the referring physician.

e. The Chief, Medical Administration Service, will be responsible for monitoring daily census and determining when the occupancy level has exceeded this medical center's ability to respond to the needs of the emergent patient. The following may be used as a general guide:

Service	Operating Beds	Census
Surgical	203	130
Medical	316	264
Psychiatry	180	155
SCI	160	152
ICU	23	20
	882	721

Sound judgment must be exercised in this matter. The Associate Chief of Staff for Ambulatory Care or his designee will be consulted when it appears the occupancy level has reached a rate beyond this medical center's ability to provide a safe environment or to provide for the emergent patient.

f. When it is determined the occupancy rate has risen to an unsafe level, the Associate Chief of Staff for Ambulatory Care or his designee will review the application for each patient to be admitted. If the patient's condition is nonemergent, he will be scheduled for admission at some future date, but within 15 days, if possible. True medical emergencies will be admitted at once. The comfort and safety of the patient is the primary consideration when evaluating applicants for future admission.

g. Eligible veterans will be admitted according to the following basic priorities (VAR 6049):

(1) Medical emergencies, service-connected veterans, and Spanish-American War veterans will have the highest priority.

(2) If hospitalization is indicated but not emergent, the non-service connected applicant will be scheduled for admission according to urgency of need, numerical priority of entitlement and availability of a bed.

h. Medical Administration Service will be responsible for determining legal entitlement for medical center treatment.

4. References. M-1, Part 1, Chapter 4; VA Regulations 6030-6060.

5. Rescission. Medical Center Memorandum 136-6, dated March 21, 1977.

Herbert S. Arnett

HERBERT S. ARNETT
Director

Distribution: B & D

VETERANS ADMINISTRATION MEDICAL CENTER
Memphis, Tennessee 38104

Memorandum No. 136-60
April 7, 1982

SUBJ: AMBULATORY CARE OUTPATIENT PROGRAM

1. Purpose. To update center policy and procedures for providing ambulatory care to eligible VA beneficiaries.

2. Policy.

a. Veterans applying for hospitalization may be furnished ambulatory care provided a determination is made by the examining physician that, in his professional judgment, ambulatory care is necessary to treat the condition which normally would require bed care or, if the condition remains untreated, it could reasonably be expected to require hospitalization in the immediate future.

b. Ambulatory care does not cover routine maintenance treatment of chronic conditions such as daily insulin injections, antihypertensive drugs, etc., which would not normally require hospital care. (NOTE: Patients being treated under the Ambulatory Care Program are not eligible for any items from the Prosthetic Treatment Center.)

3. Responsibility.

a. Admitting Area physicians and psychologists may place applicants in ambulatory care status and provide treatment required by the applicants. If a physician or psychologist wishes to place a patient in a clinic not operated by his own service, he must have his request approved by the physician in charge of the clinic in question.

b. The Chief, Medical Administration Service is responsible for the implementation, control and coordination of all administrative aspects of the Ambulatory Care Program.

c. Psychologists may place applicants in ambulatory care status on Psychiatry Service only.

4. Implementation.

a. Ambulatory care may be furnished to veterans not otherwise entitled to outpatient care under the following circumstances:

(1) An application for medical center care is made.

(2) The medical determination indicates such medical center care is necessary but can be provided on an ambulatory care basis to avoid hospitalization.

(3) Veterans under 65 years of age, or veterans not in receipt of VA compensation for a service-connected condition, or veterans not in receipt of a VA pension for nonservice-connected conditions must certify their inability to pay costs of hospital care elsewhere.

b. Staff personnel listed in paragraph 3. a. and c. will determine if ambulatory care will be provided. They will so indicate by recording this information on VA Form 10-10m, Medical Certificate.

EXPIRES APRIL 30, 1985

Memorandum 136-60
Attachment A
April 7, 1982

VETERANS ADMINISTRATION MEDICAL CENTER
Memphis, Tennessee 38104

INFORMATION SHEET FOR NONSERVICE-CONNECTED VETERAN/PATIENTS ENROLLED IN OUTPATIENT TREATMENT PROGRAMS (OPT-NSC AND AMBULATORY CARE)

(Not in receipt of Aid and Attendance, Housebound Benefits, or a veteran of World War I, Mexican Border Period and former Prisoners of War)

Under current law and Veterans Administration regulations, outpatient treatment for nonservice-connected veterans is limited. Normally, chronic nonservice connected disabilities which can be controlled by medication or diet do not qualify for outpatient treatment and medication.

Your VA physician has determined that your medical condition is now stable and you can be discharged from this clinic. If further follow-up treatment is desired, you may obtain this treatment from your local physician at your own expense since there is no authority for the VA to pay for such treatment.

Our Social Work Service staff is available for counseling regarding the use of private (non-VA) health care resources. If, in the future, your condition worsens and the potential need for hospitalization arises, you are free to either seek a Primary Care Clinic appointment by calling 577-7262, or present yourself to the Admission/Triage/Emergency Room area for evaluation of that need.

Release of Information: A form is available which authorizes a summary of your hospitalization and outpatient treatment to be sent to your private physician. If you know the name and address, you may complete the form now and leave it with the Release of Information Clerk. If you have yet to choose the physician who will care for you, take the form home with you, complete it as soon as possible, and return it to the medical center at this address:

Chief, Medical Information Section (136F)
Veterans Administration Medical Center
1030 Jefferson Avenue
Memphis, Tennessee 38104

Prescriptions: You will receive a supply of your current medications in an amount to be determined by your VA physician (but not more than a 30-day supply). There are no refills authorized for these prescriptions, and further supplies of the medications may not be furnished by the VA Medical Center Pharmacy. Medications prescribed by your local physician will have to be obtained at your own expense.

If you have any questions concerning your entitlement to VA medical benefits, please contact a member of our Medical Administration Service staff.

c. Applicants accepted for the Alcohol Program may be placed in ambulatory care status.

d. Patients may receive ambulatory care treatment for 90 days. The Section Chief or Staff Physician will document the patient's record to permit care beyond the 90 day period for all subsequent visits. If treatment is to be terminated and the treating physician feels that the patient should continue follow-up care from non-VA sources, the patient will be referred to Social Work Service for assistance, if desired. A release of information consent will be obtained so that a summary can be forwarded to the patient's physician. The patient will be provided sufficient medication to prevent interruption of his current treatment regimen not to exceed a thirty (30) day supply with no refills. The Module Clerk will provide the patient with an Information Sheet (attachment). Substance abuse, mental health and hypertensive patients are not affected by these restrictions at this time.

e. Veterans will not be enrolled in the program or retained because of social-economic reasons. It is, therefore, of paramount importance to secure the assistance of our Social Work Service staff in such instances in order to assist the veteran in securing his care from other sources at no expense to the VA.

f. Veterans who reside outside our Primary Service Area may be provided one-time treatment on the Ambulatory Care Program and then referred to the appropriate VA Medical Center nearest his residence or to other sources at no expense to the VA.

g. Prescriptions for medications to be filled by our pharmacy will be limited to the quantity needed until the next VA appointment.

h. VA Form 10-2875, Outpatient Routing List, will be used to record all visits.

i. The Medical Alert Tab will be utilized to alert all medical care professionals as to the veteran's eligibility status for the Ambulatory Care Outpatient Program. Medical Administration Service personnel will update the alert tab when medically indicated.

5. Reference. VA Regulation 6060E.

6. Rescission. Medical Center Memorandum No. 136-60, dated August 26, 1981.

BY DIRECTION OF THE DIRECTOR:

R. C. MEILER
Associate Director

Attachment: A

Distribution: B & E
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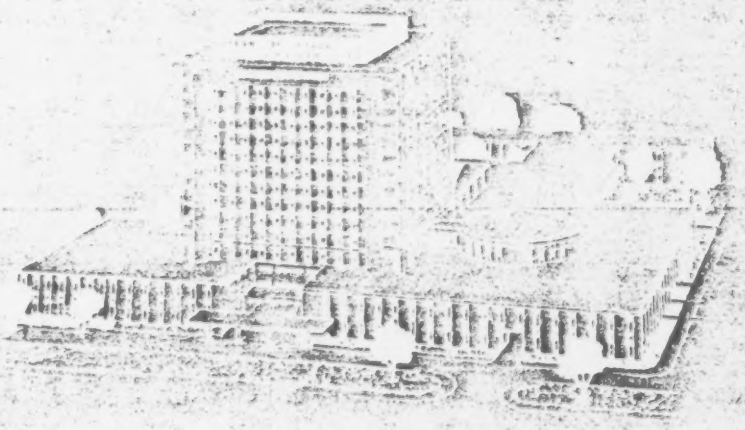
Veterans Administration

Guide to Ambulatory Care

Medical Center
1030 Jefferson Avenue
Memphis, Tennessee 38104



Welcome

The Memphis VA Medical Center and all the staff are here to serve you. Our aim is to see that you receive the high quality health care to which you are entitled.

Your cooperation is requested and will help us in making your time spent here more comfortable, as well as helping the physicians and other members of the medical team in their efforts to provide the best possible health care.

We trust that this booklet will help you understand the services and policies of the Memphis VA Medical Center.

HERBERT A. ARNETT
Director

The Emergency Room

The Emergency Room is open 24 hours, 7/days a week.

This department is equipped and staffed to give prompt medical evaluation and treatment to any person with sudden illness or injury. Treatment for life-threatening medical problems is given immediately.

Call the EMERGENCY ROOM 901-523-8990

Your call to the Emergency Room will make it possible for the staff to tell you what to do. It will also help the medical team be ready for your arrival.

Normally, family and visitors are requested to remain in the main lobby so that the veterans who are applying for treatment will have a place to sit. An Emergency Room staff physician will counsel family and friends about the patient's condition as soon as the emergency treatment is completed.

After tests have been ordered, veterans may be asked to wait for test results in the Admission waiting area. As soon as test results have been received the veteran will be notified and further informed of his/her condition and recommended follow-up.

Appointment System

To decrease waiting time for our veterans, your VA Medical Center has an appointment system. An appointment is needed to see a doctor in any clinic. Since different clinics are open only certain days, it is important to make an appointment to avoid making an unnecessary trip to the center. Calling ahead for an appointment will help to expedite your evaluation.

All clinics are closed every weekend, and on the following national holidays:

1. New Year's Day - January 1
2. George Washington's Birthday
3. Memorial Day
4. Independence Day - July 4
5. Labor Day
6. Columbus Day
7. Veteran's Day
8. Thanksgiving
9. Christmas Day, December 25

On weekends and the above holidays the Emergency Room is open.

TO MAKE AN APPOINTMENT: Call Centralized Scheduling, 901-577-7262, between 8 a.m. and 5 p.m. weekdays, or write to VA Medical Center, 1030 Jefferson Avenue, Memphis, TN 38104.

Once you have an appointment, it is very important to be on time. If you are late, you will have to wait or may be asked to make an appointment for another day.

If you cannot keep your appointment, please call Centralized Scheduling 901-577-7262 to cancel change the appointment.

Primary Care Clinic (PCC)

Primary Care Clinic is a screening clinic where veterans are seen for evaluation by appointment only. The patient's complaints are evaluated to see if he needs admission to the hospital, referral to a specialty clinic, or treatment for an acute illness that does not require hospitalization. Any veteran who is not followed in an outpatient clinic, or who is not eligible for one of the outpatient clinic programs (see page 8) should make an appointment in PCC, unless there is a true emergency.

On busy days, all available PCC appointments are filled, so it is important to call or write for an appointment. You may make your appointment to see the PCC doctor or nurse practitioner who saw you in the past.

TO MAKE AN APPOINTMENT: Call Centralized Scheduling (901-577-7262) between 8 a.m. and 5 p.m. weekdays, or write to VA Medical Center, 1030 Jefferson Avenue, Memphis, TN 38104 (Attn: 136D).

Chronic illness, such as diabetes, hypertension, and heart disease cannot be routinely treated in Primary Care Clinic.

Outpatient Clinic Modules

The outpatient specialty clinics are grouped into four Modules or Clinic centers.

MODULE A:
- Orthopedic
- Thoracic Surgery

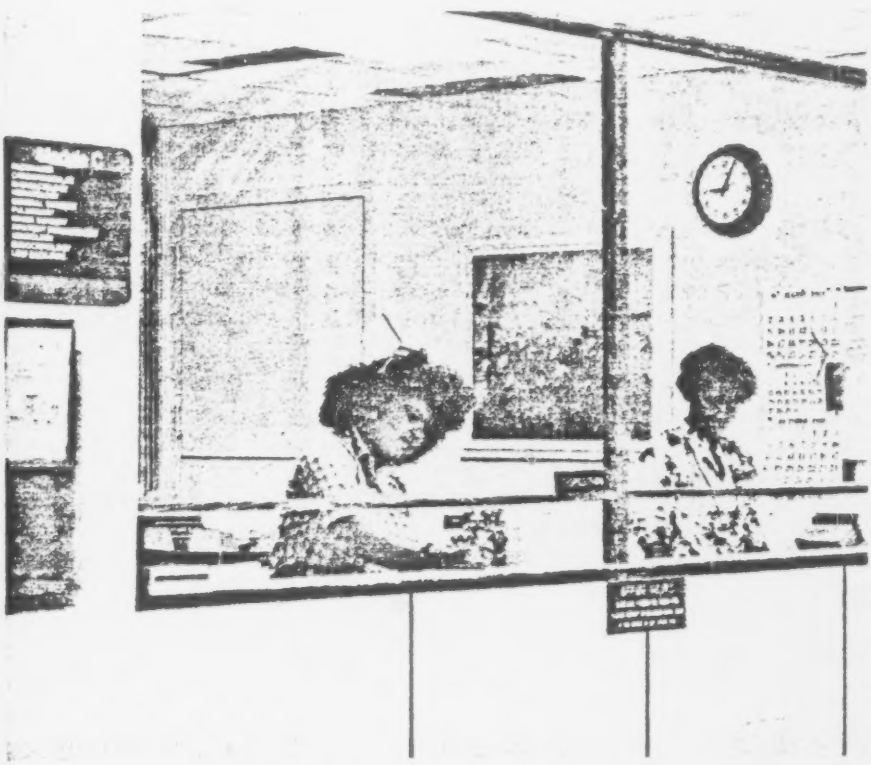
MODULE B:
- Eye
- Ear, Nose, & Throat

MODULE C:
- Cardiovascular (CV)
- Endocrinology
- General Surgery
- Hematology/Oncology
- Low Back Pain
- Minor Surgery
- Neurology
- Neurology Specialty
- Pacemaker
- Plastic Surgery
- Pulmonary
- Pulmonary Oncology
- Rheumatology
- Urology Oncology

MODULE D:
- Allergy
- Dental
- Dermatology
- Gastro-Intestinal (GI)
- Genito-Urinary (GU)
- Hypertension
- Medical Residents
- Medical Staff
- Nephrology
- Neurosurgery
- Ratings

Each module has its own staff to handle your needs. You will report directly to your module at the appointment time listed on your card. You will be directed to the assigned waiting area until the doctor calls for you. After the doctor sees you, you will report back to your Module to be given your next appointment.

Any questions about your clinic visit should be directed to your Module's clerk. Again we ask if you cannot keep your appointment, please call (901) 577-7262.



Types of Treatment Programs

OPT-SC Service-Connected Program

Service-connected veterans are entitled to receive outpatient treatment for their service-connected disability. If the veteran is rated 50% or more service-connected, the veteran is entitled to outpatient treatment for any condition, excluding dental care. Veterans rated 100% service-connected are entitled to dental care.

OPT-NSC Nonservice-Connected Program

The purpose of the outpatient treatment nonservice connected program is to facilitate an early release from inpatient care to outpatient care. Treatment may be provided for a short duration only for care directly related to the inpatient episode. As soon as the condition is stabilized, the veteran will be discharged from OPT-NSC status to the care of his/her family physician at no expense to the V.A.

A & A - Aid & Attendance Program

Veterans receiving VA pensions and an additional benefit, because they require the physical assistance or supervision of another person on a regular basis with such things as bathing, dressing, and eating, are entitled to outpatient treatment for any condition excluding dental care.

OPT-HB - Housebound Program

Veterans receiving a VA pension and an additional benefit because their health prevents them from leaving their home, are entitled to outpatient treatment for any condition except dental care.

World War I, Mexican Border Period, & Spanish American War Veterans

These veterans are entitled to outpatient treatment for any condition, except dental care.

AC - Ambulatory Care Program

The purpose of the Ambulatory Care program is solely to provide treatment to eliminate the need for immediate hospitalization if the condition remains untreated. This program allows veterans to receive outpatient care for a period up to 60 days.

Prescriptions

To get a prescri, ion filled at the VA Medical Center Pharmacy (Room CW-125), the veteran must be on an outpatient treament program such as OPT-SC, OPT-A&A, OPT-NSC or AC (see page 8 for eligibility program definitions) and the prescription must be written by a Memphis VA Medical Center doctor. If a veteran is discharged from the hospital and not scheduled to return to a clinic appointment in the Outpatient Department, he will not be eligible to receive refills on his medications.

Prescription Refills

Medications or current prescriptions may not be furnished beyond the date of the next scheduled clinic visit. Any prescriptions that may be refilled will show the number of available refills on the prescription label in the space following the word "refill". If there is no number or a zero following the word "refill", the prescription may *not* be refilled.

When refills are authorized, you may

1. Come in—Report to your Module for a routing sheet and go to the Pharmacy window and request your refills by medication name or prescription number.

2. Write to—Pharmacy Service (119), VA Medical Center, 1030 Jefferson Avenue, Memphis, TN 38104 and request your refills by medication name or prescription number. Be sure to include your full name, address, and social security number.

Anytime you inquire about your prescription, please have your social security number and medication name or prescription at hand.

Social Work Service

Social Work Service provides counseling about financial and vocational needs as well as those related to personal, family, and marital problems. Those veterans who are ineligible for care by the VA but in need of medical attention will be assisted in obtaining medical assistance through appropriate referral to community agencies. Also, in those instances where financial or housing assistance is needed, veterans and their families will be directed to the proper community resources.

Veterans Assistance Section

The Veterans Assistance Office is designed to assist veterans and their families in applying for and receiving various benefits provided by law. These benefits include non-service connected pension, service-connected compensation, educational and vocational rehabilitation benefits, GI home loans, burial and widow's benefits as well as other various questions that may arise. Should you wish to contact this servic please stop by, no appointment is necessary, or you may use the toll-free Hot Line service that has been provided.

Tennessee

Regional Office - 110 9th Avenue South
Nashville, TN 37203
In Memphis Call: 527-4583
Call: 1-800-342-8330

Arkansas

Regional Office - 1200 West 3rd Street
Little Rock, Arkansas 72201
Call: 1-800-482-5434

Mississippi

Regional Office - 100 West Capitol Street
Jackson, MS 93201
Call: 1-800-682-5270

Missouri

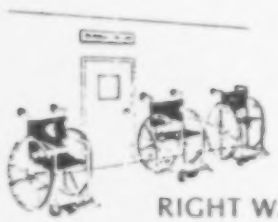
Regional Office - Federal Building
1520 Market Street
St. Louis, MO 63103
Call: 1-800-342-3761

Ambulatory Care Regulations

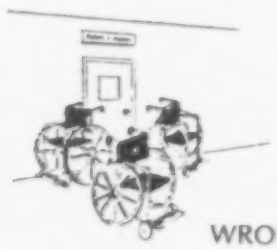
Absolutely no smoking is allowed in the Ambulatory Clinic areas. Smoke can have serious effects on some patients. On the first floor smoking is allowed in the Main Lobby and the restrooms.

Visitors are not allowed in the patients' wating area unless the patient has a condition which requires an attendant. Children are restricted from the clinic areas.

Wheelchair patients are asked to park in a way which does not block the wall or doorways.



RIGHT WAY



WRONG

Family members, children and friends are asked to wait in the Main Lobby while the veteran is being seen in a clinic.

The information desk in the Main Lobby tells visitors which room and ward patients are on.

Refreshments are available in the Canteen on the second floor of the Medical Center.

Chairman SIMPSON. Now, Dr. Houston, please.

Dr. HOUSTON. Mr. Chairman, I am very appreciative of the opportunity to present my views on the subject of outpatient care, especially as it pertains to the State of Florida.

Florida is one of the three fastest growing States in the country. From 1970 to 1980 the overall population rose from 6.7 to 9.7 million, a 43-percent increase in 10 years. Florida is now the seventh largest State in the Union by both total population and veteran population and is expected to rank fourth by 1990. By the year 2000 the Florida veteran population will increase from 1.3 to 2.6 million, a 100-percent increase, while the national population will drop from 30 to 27 million, a 10-percent decrease.

The dramatically increasing veteran population in Florida will result in a significant increase in demand for VA health care. Also, the Florida veteran population includes a high percentage of older and more disabled veterans.

In fiscal year 1981, 15.4 percent of the applicants for medical care in Florida were 65 years of age or older versus 11.7 nationwide. By the year 2000 a 550-percent increase in veterans age 65 to 74 and a 775-percent increase in veterans over age 75 are projected. There is a greater demand for VA health care by the over 65 age group for both inpatient and outpatient treatment. For example, the staff outpatient visit rate per 1,000 veterans over age 65 is two to three times that of veterans under 65; 44.4 percent of Florida's veterans are service connected compared to 33 percent nationwide and 15.3 percent are aid and attendance and/or VA pension recipients compared with 13.8 nationwide.

In Florida, where the demand for care exceeds the supply of available VA resources, enrollment into outpatient treatment programs is restricted to the legislated priority levels for which appropriate care can be provided. VA facilities in Florida now handle a higher percentage of higher priority outpatient visits than any other VA medical district in the Nation.

As the population and age of veterans increase, we in the State of Florida will be forced to deny VA care to some veterans in higher priority categories unless additional resources are made available.

Whether the VA method of resource allocation is giving consideration to the changing geographic and demographic situation is impossible for me to evaluate. I am aware of the needs of the Florida veterans, but only our central office is in a position to evaluate these needs relative to those of other areas in the Sun Belt and elsewhere.

The VA provides primary, secondary, tertiary, acute, and chronic care to veterans who have legislative priorities residing in the proximity of a VA facility. For those non-service-connected veterans who do not have legislative priorities, the VA provides acute care on an outpatient basis, and acute and chronic care on an inpatient basis.

The growth in the female population is recognized.

Within the resource limitations, the priorities of care established by Congress determine that veterans are going to be provided care within a reasonable timeframe. In my opinion, once a veteran enters a treatment system it is not only appropriate, but necessary

to include all medications indicated for the treatment of the veteran's condition; to do less would jeopardize the treatment program.

The Fort Myers VA Clinic is the only VA clinic in southwest Florida. The clinic opened on November 5, 1979. It is a satellite of Bay Pines to who we refer 95 percent of our admissions and consultations. Emergent cases are hospitalized in local non-VA hospitals. Approximately 3 percent of the patients go to Tampa VA and 2 percent to Miami VA.

The clinic is essentially a primary care provide with no specialty clinics and a 6.5 FTEE MD with internal medicine, psychiatric, and radiology expertise.

The clinic was programed for 18,000 visits with 45 FTEE in fiscal year 1980 and realized 23,806 visits. The fiscal year 1981 was programed for 25,000 and realized 26,056.

The Fort Myers Clinic catchment includes six full counties and the southern half of two others. From 1970 to 1980 the census of this area rose from 349,000 approximately to 643,000, an increase of 84 percent. Metropolitan Fort Myers, Cape Coral, and Lehigh Acres, with a population of 85,000, has 21,000 resident veterans. The total catchment for the clinic area is 57,000 veterans.

Additional observations: That the increasing veteran population of Florida and especially southwest Florida is well documented by the local census bureaus, the county service officers, veterans' county service officers and by the increased demand for medical treatment in the various medical outpatient facilities, as witnessed by the AMIS reports.

That the medical needs of the older veteran is more comprehensive and expensive: Multiple services and multiple supplies.

Home nursing care could support the chronically ill at lower costs. Transportation for the older veteran is complicated.

There is a growing need for the nursing home.

As the deductible increases with medicare more requests will be made of the VA for supportive services.

Use of day care centers for selected service-connected mental health patients could reduce the cost of care for some of these patients.

The medical needs of the veterans over age 65 cannot be appropriately met without reliance on an outpatient program.

Thank you.

Chairman SIMPSON. Thank you very much, Dr. Houston.

[The prepared statement of Dr. Gilbert Houston, Chief Medical Officer, Veterans' Administration Outpatient Clinic, Fort Myers, Fla., and his responses to written questions submitted by Hon. Alan K. Simpson, chairman of the Senate Committee on Veterans' Affairs and Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs, follow:]

PREPARED STATEMENT OF DR. GILBERT HOUSTON, CHIEF MEDICAL OFFICER, VETERANS' ADMINISTRATION OUTPATIENT CLINIC, FORT MYERS, FLA.

Mr. Chairman and Members of the Committee:

I am very appreciative of the opportunity to present my views on the subject of outpatient care, especially as it pertains to the State of Florida.

Florida is one of the three fastest growing states in the country. From 1970 to 1980 the overall population rose from 6.7 million to 9.7 million, a 43% increase in 10 years. Florida is now the seventh largest state in the union by both total population and veteran population and is expected to rank fourth by 1990. By the year 2000 the Florida veteran population will increase from 1.3 million to 2.6 million, a 100% increase, while the national

veteran population will drop from 30 million to 27 million, a 10% decrease.

The dramatically increasing veteran population in Florida will result in a significant increase in demand for VA health care. Also, the Florida veteran population includes a high percentage of older and more disabled veterans.

In FY 1981, 15.4% of applicants for medical care in Florida were 65 years or older versus 11.7% of applicants VA-wide. By the year 2000 a 550% increase in veterans age 65-74 and a 775% increase in veterans over age 75 are projected. There is a greater demand for VA health care by the over 65 age group for both inpatient and outpatient treatment. For example, the staff outpatient visit rate per 1,000 veterans over age 65 is two to three times that of veterans under age 65. Forty-four point 4 percent of Florida's veterans are service connected compared with 33.0% nation-wide and 15.3% are Aid and Attendance and/or VA pension recipients compared with 13.8% nation-wide.

In Florida, where the demand for care exceeds the supply of available Va resources, enrollment into outpatient treatment programs is restricted to the legislated priority levels for which appropriate care can be provided. (See attachment 1). VA facilities in Florida now handle a higher percentage of the higher

priority outpatient visits than any other VA medical district in the nation. Workloads for outpatient clinics in Florida including the percent of higher priority workloads, for FY '79 through the 1st 6 months of FY '82 are shown in Attachment 1.

As the population and age of veterans increase, we in the State of Florida will be forced to deny VA care to some veterans in higher priority categories unless additional resources are made available.

The inability to provide VA care to service connected veterans, the highest priority group, in the foreseeable future is a possibility. The VA health care delivery system could certainly adapt to meet the current and projected health care needs of Florida's veterans but this can be accomplished only with increased resources.

Whether the VA's method of resource allocation is giving consideration to the changing geographic and demographic situation is impossible for me to evaluate. I am aware of the needs of Florida veterans, but only our Central Office is in a position to evaluate these needs relative to those of other areas in the Sunbelt and elsewhere.

The VA provides primary, secondary, tertiary, acute and chronic care to veterans who have legislative priorities residing in

proximity to a VA facility. For those non-service connected veterans who do not have legislative priorities, the VA provides acute care on an outpatient basis, and acute and chronic care on an inpatient basis.

The growth in the female veteran population is recognized, as is the growing need for the provision of gynecological services. In all other aspects, female veterans have the same accessability to VA outpatient care as male veterans.

Within resource limitations, the priorities of care established by Congress determine which veterans are going to be provided care, within a reasonable time frame. In my opinion, once a veteran enters a treatment program it is not only appropriate, but necessary to include all medications indicated for the treatment of the veteran;s condition. To do less could jeopardize the treatment program established.

Fort Myers Clinic

The Fort Myers VA Clinic is the only VA clinic in Southwest Florida. This Veterans Administration clinic resulted from the cooperative efforts of many individuals and organizations who envisioned the present and future need for medical treatment of the growing veteran population in the Southwest Florida area.

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Veterans had to travel 125 to 145 miles for care in either of three directions; Bay Pines, Tampa or Miami. When in an emergent condition it was impossible to secure outpatient or hospital care at these centers. When it was thought the veteran had an emergent condition he relied on local non-VA medical sources. This problem is compounded during the tourist season.

The clinic opened November 5, 1979. It is a satellite of Bay Pines and refers approximately 95% of its admissions and consultations to that facility. Emergent cases are hospitalized in local non-VA hospitals. Approximately 3% go to Tampa VA and 2% go to Miami VA.

The clinic is essentially a primary care provider with no speciality clinics and 6 1/2 FTEE MD's with Internal Medicine, Psychiatric and Radiology expertise. There are two Physician's Assistance. There is one dentist. Consultants stipend of $75.00 for two hours (number of patients varying per session) is noncompetitive with local office fees. Recruitment of personnel is difficult in both the professional and technical fields for this reason.

The clinic was programmed for 18,000 visits with 45 FTEE in FY 1980 and realized 23,806 visits. The FY 1981 was programmed for 25,000 and realized 26,056 visits. The FY 1982 workload is equal or greater than that of FY 1981.

Fee basis for local treatment of veterans is simply not available in certain specialities such as orthopedics, dermatology, etc., because of the financial limitation on the care. The local professionals request their fee at the time of the visit, this is especially true of veterans since they feel the paper work is unrealistic and the wait for their money is too long from the VA. Fort Myers Clinic is a satellite of Bay Pines and logistically distance presents problems for many reasons and local facilities must be utilized. Mental Health with greatly limited services in the community and the seriously ill patient presents the most problems.

Transportation from Fort Myers to a VA hospital is either personal conveyance, cab, or airplane. (See Attachment 4). Ambulance transport requires 24 hours notice. EMT transport to local hospitals is efficient and competent.

The Fort Myers Clinic catchment includes six full counties and the southern half of two others. From 1970 to 1980 the census of this area rose from 349,329 to 643,579, an increase of 84 percent. Metropolitan Fort Myers, Cape coral and Lehigh Acres, with a population of 85,000 has 21,000 resident veterans. The total catchment has 57,000 veterans. New highways, bus service, and clinic location make it very accessible from the fastest growing areas in Southwest Florida.

Additional Observations:

1. That the increasing veterans population of Florida and especially Southwest Florida is well documented by the local census bureaus, veterans county service officers and by the increased demands for medical treatment in the various medical outpatient facilities (AMIS Reports).

2. That the medical needs of the older veterans is more comprehensive and expensive (multiple service and supplies).

3. Home nursing care could support the chronically ill at lower costs. Transportation for the older veteran is complicated (attendant, type of vehicle, timing and cost).

4. There is a growing need for nursing homes.

5. As the deductible increases with Medicare more requests will be made of the VA for supportive services.

6. Use of Day Care centers for selected service connected mental health patients could reduce the cost of care for the patient.

7. The medical needs of Veterans over age 65 cannot be appropriately met without reliance on an outpatient program.

Attachments 4
1. Outpatient Care Priorities
2. Outpatient Clinic Workload
3. Ft. Myers Clinic Workload
4. Transportation/Cost/Trip

OUTPATIENT CARE PRIORITIES

As required by Title 38 U.S.C. Chap.17, Section 612(i) the following priorities and instructions for implementation have been prescribed by the Chief Medical Director.

VA Manual M-1, Part I, Chapter 17, Change 10...

"When the demand for care is consistently greater than the care which can be provided with available resources, restrictions on accepting new applicants will be imposed by the health care facility Director. In such event, admission of applicants to outpatient programs will be restricted by not accepting applicants from priority categories below the priority level where appropriate care can be provided within available resources."

In accordance with M-I, Part I, Chapter 17, Change 10 and II 10-80-5 and 10-81-48; DM&S Cir. 10-81-249, DM&S Cir. 10-81-250, the following seven priority listings define those veterans eligible for outpatient treatment. Priority I veterans have the highest priority for care, while Priority 7's have the lowest priority for care.

Priority Group I

a. Veterans requiring care for service connected disabilities incurred in line of duty for which they were released or retired from the active military, naval or air service. (This category also includes Spanish-American War veterans requiring care for any disability.)

b. Veterans with a service connected disability or retired for disability rated at 50% or more.

c. Veterans with service connected disabilities or retired for disabilities incurred in line of duty, requiring care for non-service connected disabilities.

Priority Group II

a. Former Prisoner of War

b. Veterans of the Vietnam Era whose condition has been determined to be the result of exposure to dioxin, toxic substances in herbicides or defoliant used for military purposes.

c. Veterans who while serving on active military duty have a condition which has been determined to be the result of exposure to ionizing radiation from the detonation of a nuclear device as a result of participation in either the testing of such a device or the American occupation of Hiroshima or Nagasaki, Japan, between September 11, 1945 and July 1, 1946.

Priority Group III

a. Veterans in receipt of increased pension or special allowance based on the need of regular aid and attendance or by reason of being permanently housebound, or who, but for the receipt of retired pay, would be in receipt of such increased pension or special allowance.

b. Veterans of World War I or Mexican Border period.

Priority Group IV

a. Compensation or pension examinations and examinations for VA insurance purposes.

b. Veterans entitled to vocational rehabilitation training who are receiving or in need of such training and medical services are determined necessary for any of the reasons given in VA Regulation 6036B.

Priority Group V

a. Non-service connected veterans requiring post hospital care (OPT-NSC).

b. Non-service connected veterans requiring PBC (pre-bed care).

Priority Group VI

a. Non-service connected veterans requiring care to obviate the need for hospitalization (Ambulatory Care Program).

b. Former members of the Armed Forces retired from the service on the basis of lenght of service who are to be provided outpatient care as beneficiaries of the Armed Forces.

Priority Group VII

a. Persons treated under sharing agreements.

b. Beneficiaries from other Federal agencies, except as described in Priority VI b.

c. Veterans of nations allied with the United States in World War I or II receiving medical care under the authority of 38 U.S.C. 109(a).

OUTPATIENT CLINIC WORKLOAD - M. D. 12

Outpatient Clinics		FY-79	FY-80	FY-81	Proj. FY-82 based on 1st 6 mos.
Ft. Myers	Outpatient Visits	-	22,867	25,312	27,359
	* % highest priority	-	79.9	90.0	92.8
	** % service-connected	-	39.0	54.8	67.1
St. Petersburg	Outpatient Visits	69,140	67,651	73,336	58,483
	% highest priority	86.8	86.6	85.4	84.0
	% service-connected	78.2	78.5	78.2	77.1
Jacksonville	Outpatient Visits	39,196	38,157	63,683	41,164
	% highest priority	82.8	78.2	78.1	82.0
	% service-connected	60.2	60.1	61.1	66.3
Riviera Beach	Outpatient Visits	45,804	49,497	50,252	48,945
	% highest priority	65.2	67.2	68.0	70.9
	% service-connected	56.4	58.6	60.9	64.5
Oakland Park	Outpatient Visits	-	-	-	22,339
	% highest priority	-	-	-	81.5
	% service-connected	-	-	-	51.5
Orlando	Outpatient Visits	49,963	57,241	60,771	56,977
	% highest priority	76.7	82.8	83.8	87.4
	% service-connected	62.7	69.3	71.2	75.4
OPC Total Visits		204,103	235,413	253,354	255,267

* Highest Priority visits include compensation and pension exams, applications for medical care (10-10's), and service-connected outpatient treatment visits.

** Service-connected outpatient visits include only those being treated for a service-connected disability.

Attachment 2

		C&P	Walk-ins 10-10	Appointments SC	Appointments NSC	Prescription	Collateral	Non-Vet	Total
FY '80	11-79	-	840	540	404	-	3	-	1787
	12-79	21	846	1002	665	12	3	-	2549
	1-80	27	996	1396	746	64	9	-	3238
	2-80	25	820	725	340	87	16	-	2013
	3-80	27	848	731	307	97	14	-	2024
	4-80	35	845	904	331	94	38	1	2248
	5-80	32	733	655	301	101	34	-	1856
	6-80	27	788	744	275	122	26	-	1982
	7-80	36	808	718	317	115	25	-	2019
	8-80	34	675	654	378	144	17	2	1904
	9-80	24	859	856	260	157	28	2	2186
TOTAL		288	9058	8925	4324	993	213	5	23,806
FY'81	10-80	35	788	776	178	141	16	3	1937
	11-80	44	934	893	195	161	21	3	2251
	12-80	23	767	966	184	126	26	1	2093
	1-81	26	1183	1090	250	145	30	1	2725
	2-81	22	873	948	186	152	25	1	2207
	3-81	23	844	1252	178	36	33	-	2366
	4-81	42	635	1416	188	11	30	-	2322
	5-81	29	491	1241	147	8	34	-	1950
	6-81	25	561	1303	129	9	43	-	2070
	7-81	32	510	1298	170	18	44	-	2072
	8-81	27	442	1267	93	16	50	-	1895
	9-81	24	522	1418	129	31	44	-	2168
TOTAL		352	8550	13868	2027	854	396	9	26,056

Attachment 3

		C&P	Walk-ins 10-10	Appointments SC	Appointments NSC	Prescription	Collateral	Non-Vet	TOTAL
FY'82	10-81	23	488	1517	141	20	45	-	2234
	11-81	26	586	1427	120	38	33	-	2230
	12-81	37	509	1593	126	33	32	-	2330
	1-82	29	552	1546	113	87	37	-	2364
	2-82	33	516	1371	116	71	29	-	2136
	3-82	17	649	1582	130	78	39	-	2495
	4-82	25	548	1471	132	84	52	-	2312
	5-82	30	512	1310	95	88	53	-	2088
FY '80		288	9058	8925	4324	993	213	5	23,806
FY '81		352	8550	13868	2027	854	396	9	26,056
FY '82 - May		220	4360	11817	973	499	320	-	18,189
TOTAL									68,051

TRANSPORTATION - COST/TRIP

Emergency Medical Service (Ambulance)	
To local hospital:	$100.00
Mileage	$ 2.50 per mile (approx. 2 miles to each local hospital)
To Bay Pines Hospital	$525.00 (Ambulance requires 24 hour notice.)
To Tampa VA	$525.00
BLUE BIRD TAXI	
To Bay Pines VAH	$150.00
To Tampa VAH	$160.00
Am-Tran (Non-Emergent Transport)	
To Bay Pines VAH	$265.00
To Tampa VAH	$265.00
Blaine Aviation (Air Transport)	
To Bay P-nes VAH	
Transport by EMS to	
Ft. Myers Airways:	$105.00
Air Ambulance to Bay Pines: $200.00 ($240.00 if needs attendant).	
Ambulance to transport	
to Bay Pines	$ 75.00
or Taxi	$ 20.00

Attachment 4

RESPONSE OF DR. GILBERT HOUSTON, CHIEF MEDICAL OFFICER, VETERANS' ADMINISTRATION OUTPATIENT CLINIC, FORT MYERS, FLA., TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN K. SIMPSON, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1.

If the Federal Government were to decrease its role in providing Medicare and Medicaid health insurance by continuing to implement higher deductibles and co-payments during the next 5 to 10 years, please comment on the impact such action would have on your VA outpatient workload.

Answer 1.

The request for services at our clinic by veterans, especially non-service connected veterans on Medicare and Medicaid seeing private physicians is already evident. Prosthetic needs and dental care are important to them but cost of their medication is their paramount concern. There is no question that there would be a significant increase in our workload if the deductibles and co-payments were to increase over the years.

Question 2.

Please comment on the ability of the VA outpatient system to care for non-service connected veterans with one or more chronic health problems. I am referring to those veterans who have chronic health care problems, but are unable to utilize or have exhausted other forms of community health care resources.

Answer 2.

The veterans with chronic health problems place multiple and comprehensive demands on the health care delivery system. The majority of these problems could be handled by competent internal and general practice physicians if funding and staffing were available. Certain chronic conditions such as high blood pressure, diabetes, etc., could, if untreated, lead to more serious complications requiring long term hospitalization and rehabilitation.

Question 3.

Is the outpatient statutory priority system clearly understood by the VAMC administrative personnel who must implement its restrictions.

Answer 3.

Yes.

Question 4.

Please explain your screening process for potentially eligible veterans who seek outpatient health care in your clinics.

Answer 4.

The veteran presents himself at the reception desk. He is registered, interviewed alone, or with his family, by MAS personnel in individual booths. If the veteran's condition is emergent this procedure is foregone and he or she is taken immediately to the Life Support room. Following completion of VA Form 10-10, the veteran is referred to the waiting area. A medical record is made up and placed in a tray in a triage area marked either SC or NSC. The time of entry into the clinic is

recorded on the routing sheet, VA Form 10-2875. The service connected veterans are processed first. All veterans are interviewed by the nurses in triage and counseled regarding their treatment and eligibility. Their record is then placed in a designated box for a physician or physicians' assistant. The individual is then evaluated by the health care provider. Those veterans needing further assistance are referred to the eligibility clerk, Social Service, or the DAV, whichever seems most appropriate.

Question 5.

Do the veterans generally understand the process and accept the restrictions.

Answer 5.

Under the procedures detailed above, in answer to question 4, we have had few complaints or hostile reactions. If the veteran is not satisfied he has access to the Medical Administrative Officer or the Chief Medical Officer.

Question 6.

Does the clinic administrative staff find the process hard to interpret and implement.

Answer 6.

No.

Question 7.

If the present eligibility remains unchanged and increasing numbers of eligible aging veterans attempt to utilize the VA system, how will you further adapt your screening process.

Answer 7.

It would be necessary to further implement the priority system and restrict care in an inverse order of priority.

Question 8.

Please comment on how your clinic is reimbursed by the VA for the services it provides to veterans.

Answer 8.

The Fort Myers Clinic is a satellite of Bay Pines Veterans Administration Medical Center. The clinic is programmed for a designated number of outpatient visits per year. Funding is based on available resources for this workload.

Question 9.

What will be the impact of growing eligibility on present staffing, resources and funding of your outpatient clinic.

Answer 9.

As Southwest Florida is a rapidly growing area (migratory and permanent) of older people, there would be a significant impact on staff resources and funding. We are currently providing adequate care with the current staff and budget. Additional workload without funding and staff would have a tremendous impact on the quality of care we provide.

Question 10.

Do veterans in different geographic areas receive different levels of care, in terms of beneficiary travel, over-the-counter drugs, dental care, etc.

Answer 10.

Yes.

Question 11.

What efforts, including programmatic innovations and studies, are being made to ensure that high quality medical care continues to be provided at VAMC's Outpatient Clinics, given increased numbers of eligible veterans and decreased resources.

Answer 11.

The Veterans Administration has established methods of follow up on the quality of care it provides. This covers a wide area of administrative and professional scope. One of these which is being utilized by the VA is the Quality Assurance Program.

Question 12.

Do any of you have a problem of conflicting demands between your academic and clinician responsibilities, as outpatient physicians within affiliated VAMC's.

Answer 12.

Not applicable.

Question 13.

We have heard you all comment on the competition among service connected and non-service connected veterans for outpatient VA health care. What further steps should be taken to change this popular notion that non-service connected veterans are eligible for unlimited health care.

Answer 13.

An educational program through the various forms of media should be initiated to change the popular notion that non-service connected veterans are eligible for unlimited care in an outpatient setting. The veterans organizations to which they belong should be utilized in this process. Specific emphasis should be placed on the difference between the meaning of entitlement and eligibility. At the time of discharge from the Armed Forces, the veteran should be made aware of the benefits available through the VA.

Question 14.

Do you have specific suggestions to improve the management system in your hsopitals so that the outpatient programs could be run more effectively.

Answer 14.

Our relationship with Bay Pines VA Medical Center is excellent. It has been noted that the continuity of care diminishes when patients are referred to VA affiliated facilities. It is suggested that a nationwide study be made to ascertain the acceptance and rejections of patients referred to affiliated versus non-affiliated VA hospitals.

Question 15.

I understand from your testimony that the Fort Myers Outpatient Clinic treats more veterans over age 65 than other VA Outpatient Clinics throughout the nation, due to its southern Florida location. In light of your unique situation there, please comment on the "primary care" model for treating chronic illnesses that both Dr. Baker and Dr. Bickers support in their testimony, as a quality, cost-effective method of serving the non-service connected, aging veteran population.

Answer 15.

There are no specialty clinics and a very limited number of consultants at the Ft Myers VA Clinic. Family practitioners are the main providers of primary care. The needs of the older veterans are usually multiple and comprehensive. When placing this type of veteran in the system he can best be cared for and controlled on a continuing basis by the same health provider. The veterans needs are better known and because of his confidence in the physician and his compliance in treatment, episodic care is greatly reduced. This method of treatment also helps to minimize inappropriate admissions to hospitals and nursing homes. The quality of care is therefore maximized. However, it must be provided by competent and dedicated health care individuals supported by the nurses and social services. More consultants could be utilized by our clinic but the present fees are not competitive with those in the area due to our unique location. Fee basis is used for eligible veterans when we are unable to provide needed care and appointments are made in specialty clinics at Bay Pines which is 125 miles away.

The Fort Myers clinic personnel are readily visible and accessible to provide care for the veteran. The greater majority of health problems can be managed and generally stabilized by the continuing care from the same health providers. If the continuity of care in the clinic could be coordinated with the expertise of available local specialists the "primary care" concept could be nearly in place. There would be less travel, discomfort (older veterans), rapid results, care to obviate hospitalization, and more appropriate disposition of cases.

Obviously with more supportive services the workload would increase. There would be need for more personnel and funding. I believe that the chronically ill disabling veterans can be given quality care on a long term basis and in a cost effective manner provided the comprehensive approach is supported by competent health providers with adequate funding and resources.

Question 16.

Were veterans outpatient fee basis cards taken away when your clinic opened. If not, why not.

Answer 16.

Yes.

Question 17.

What are the VA's plans for improving or expanding outpatient care in Florida. Please be specific.

Answer 17.

The following are the VA plans for improving and expanding health care in Florida:

1. The opening of the new Bay Pines Medical Center for outpatient and inpatient care in 1982. The St. Petersburg Outpatient Clinic is being transferred to this location.

2. Projected satellite Outpatient Clinic for Pensacola, Florida in the summer of 1984.

3. The addition of $1,000,000 and 13,500 visits for Miami beginning in Fiscal Year 1983. There are also plans for expanding the facility for outpatient services with construction of a $49,000,000 ambulatory care and spinal cord injury unit.

4. Orlando VA Outpatient Clinic has been authorized 20,000 additional outpatient visits.

Question 18.

Are there any "travelling clinics" in southern Florida, such as the experimental clinics in Wyoming and Nebraska, given the great demand in Florida for VA outpatient health services, and the distances between the FA vacilities there.

Answer 18.

No.

Question 19.

Do you believe this experiment could be a cost effective way to meet ballooning outpatient demands for veterans who live far from VA facilities.

Answer 19.

Presently there are no "travelling clinics" in Southwest Florida. This possibility is being given consideration by MEDIPP.

RESPONSE OF DR. GILBERT HOUSTON, CHIEF MEDICAL OFFICER, VETERANS' ADMINISTRATION OUTPATIENT CLINIC, FORT MYERS, FLA., TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN CRANSTON, RANKING MINORITY MEMBER OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1. A.

Please describe the process whereby a veteran is determined to be eligible for outpatient care at your facility.

Answer 1. A.

When a veteran presents himself to our clinic seeking treatment he is asked to provide documentation that he is a veteran with an honorable discharge. If he does not have documentation we attempt to obtain verification by contacting BIRLS (Beneficiary Identification and Records Locator Subsystem). If there has been BIRLS input, we can retrieve the information within a few minutes. In the event the veteran has never filed a claim for any VA benefits, and there has been no BIRLS input, he is requested to present proof of honorable service as soon as possible. Necessary treatment is never denied pending receipt of this proof. If the veteran reports with proof of honorable service and is claiming Service Connection, Housebound, Aid and Attendance, or POW status, he is processed as a high priority veteran pending verification of status. World War I veterans are also provided this high priority treatment. Their eligibility can be determined from the discharge alone. We proceed to verify eligibility by contacting TARGET which is a computer connected to all VA Regional Offices, and it provides ready access of eligibility status on all veterans receiving monetary benefits. If computer information is not available our next step is to send a VA Form 7131 (Exchange of Beneficiary Information) to the VA Regional Office holding the veteran's claim file.

Question 1. B.

Who makes this determination, and how and by whom is the veteran advised of an adverse determination?

Answer 1. B.

The Eligibility Clerk determines eligibility based on information provided by the appropriate VA Regional Office, or in the event the veteran served in World War I by verification of honorable service. The Eligibility Clerk notifies the veteran orally if he is present, of his eligibility status, or by written correspondence, if appropriate.

Question 1. C.

Please provide a copy of all written guidance issued at your facility relating to this determination.

Answer 1. C.

The Eligibility Clerk is guided by VA Regulations, Manuals, and applicable Public Laws. There is no written guidance issued by this facility.

Question 1. D.

What efforts are made to advise veterans of the outpatient care eligibility criteria?

Answer 1. D.

The veterans are advised at registration and triage. If there is any question they are referred to the Eligibility Clerk. Further recourse, when necessary, is to Medical Administrative Officer and the Chief Medical Officer.

Question 2. A.

Who in your facility makes the determination that a veteran is eligible for fee-basis care?

Answer 2. A.

The Eligibility Clerk determines who is and who is not eligible for fee basis. The Chief Medical Officer reviews the request and recommends fee basis of a specific nature based on the record and present history. This is then forwarded to a physician in fee basis at Bay Pines for approval. If there is any question regarding the recommendation, the approving physician calls the Chief Medical Officer of the clinic and appropriate adjustments are made.

Question 2. B.

To what extent is this determination thereafter reviewed or monitored by a physician?

Answer 2. B.

Records of veterans who are legally eligible for outpatient care on a fee basis are reviewed by the authorizing medical officer at the clinic of jurisdiction for determination of medical eligibility, that is, the need for recurring outpatient treatment. I.D. cards are issued for two years at which time need for recurring treatment is again reviewed by the authorizing medical officer at the clinic of jurisdiction. Treatment plans from fee basis physicians are routinely reviewed for all treatment in excess of $55.00 per month.

Question 3. (i)

When a patient requiring post-hospital care is determined to be eligible for fee-basis care -- (i) what, if any contact do VA physicians make with the fee basis physician?

Answer 3. (i)

Routinely all patients being discharged from VA hospitals are asked to sign a release of medical information form so that a copy of their hospital summary may be forwarded to their private physician.

Question 3. (ii)

When a patient requiring post-hospital care is determined to be eligible for fee-basis care -- (ii) what instructions or specifications as to the nature of fee basis care authorized does a VA physician provide?

Answer 3. (ii)

Post hospital care patients requiring fee basis are usually provided fee basis care on a short term basis. Written instruction is given to the Health Care provider specifying the type and amount of care that is to be given. Unlike the Fee Basis I.D. card, the short term care is specific in the number of treatments that can be provided.

Question 4.

What criteria are followed in determining eligibility for each category of patients referred for fee-basis care?

Answer 4.

Legal eligibility is determined in accordance with MI, Part I, Chapter 18.

Question 5.

In terms of numbers of patients, dollars expended on the care, and episodes of care, what amount of fee-basis care is provided in each category for which it is authorized?

Answer 5.

This clinic does not have jurisdiction over fee basis. VAMC at Bay Pines has this authority.

Question 6. A.

At your facility is referring patients to other VA and U.S. Government facilities accessible to the veteran considered before arranging fee-basis care?

Answer 6. A.

Yes, provided the problem is not emergent and the services are available at the receiving VA hospital. This clinic is approximately 135 miles from the VAMC Bay Pines, Tampa, and Miami. Fee basis care is only recommended when VA facilities are not available to the veteran and the veteran is legally entitled.

Question 6. B.

Please provide copies of any current written guidance issued at your facility relating to consideration of such referrals.

Answer 6. B.

We are currently using VA directives issued by VACO.

Question 6. C.

Approximately how many patients per year are referred to such facilities.

Answer 6. C.

To date 804 referrals for FY 1982 have been made.

Question 7. A.

Where do veterans whom your clinic must turn away seek care?

Answer 7. A.

They seek care from the local private medical community, emergency rooms, and local public health clinics. Retirees who are non-service connected are referred to military facilities.

Question 7. B.

To what extent do veterans denied care at your facility have the monetary resources or insurance to cover medical costs incurred elsewhere?

Answer 7. B.

Military retirees who are non-service connected or have less than 50 percent service connection disability have medical care available to them from military bases, CHAMPUS, and Medicare with and without supplemental insurance. The majority of NSC veterans have minimal or no insurance coverage. Of the patients who use private medical doctors those over 65 are covered by Medicare. Most find the deductible for inpatient care affordable but because of the lack of benefits under this plan for outpatient coverage, they are fearful. Those who are under 65 and do not meet the eligibility or medical requirements for outpatient care usually have no insurances and are forced to rely on emergency room services.

Question 7. C.

What efforts are made at your facility to assist these veterans in locating alternati sources of care?

Answer 7. C.

The veterans are referred to Social Service who in turn determines the best alternative of limited local resources or investigates the possibility of the veteran applying for A&A.

Question 8. A.

How many outpatient visits is your facility budgeted for in fiscal year 1982 and is the number of outpatient visits made to date consistent with this level?

Answer 8. A.

25,000. Yes.

Question 8. B.

How many outpatient visits does your facility's budget provide for in fiscal year 1983, and what do you project as the demand for such care?

Answer 8. B.

For FY 1983 the facility is budgeted for 25,000 visits. It is anticipated that 27,000 visits could be attained (1981, 26,056).

Chairman SIMPSON. Let me ask some questions. Could you please comment on the effectiveness of the VA outpatient clinic budgeting method which authorizes this outpatient care funding based on annually assigned numbers of clinic treatment visits. How are those numbers of authorized visits determined? I would be interested in that. Does anybody care to tackle that one?

Dr. HOUSTON. I'll tackle it. We are not associated with a hospital in a sense of proximity. We are 125 miles away from any one of three hospitals, but we are a satellite of Bay Pines. They take care of our budget and they also set our load. And we try to maintain that load, or within reason. There are certain things that one can do and one can't do and namely, that is walk-in patients are not controllable, only to a certain degree.

In other words, you can schedule patients but you have walk-ins too. So we try to stay within reason and so far to date we have done pretty well.

Dr. BICKERS. It seems to me, Senator Simpson, that it has to do with a matter of allocation of funds which is a centrally directed function. And that quotas, if you will, because of the allocation of those funds are handed down and are given to the local medical center.

Chairman SIMPSON. Do you have any suggestions for changing or improving this funding allocation method?

Dr. BICKERS. Well, of course everybody wants more money.

Chairman SIMPSON. Yes, I've thought of that.

Dr. BICKERS. In this day and time there is more and more requests for money. It would seem that somehow the basis characteristics of the population and the population itself needs to be more carefully defined, and that the health-care delivery somehow should begin with the population that it is being designed to serve. Therefore, beginning at the bottom working up rather than beginning at the top with an appropriation of money and the determination of workload. And then let the devil receive the rest, you know, at the bottom.

Chairman SIMPSON. I am interested in the quality of care and the population cared for, and of course, that quality of care provided at your clinics is evaluated by the VA Central Office, is that correct? That is correct?

Dr. BICKERS. Yes.

Chairman SIMPSON. And do you think that evaluation method is effective? If not, what would be done to be more helpful to establish uniform standards? Can you share that one.

It's your day in the barrel.

Dr. BAKER. It's been very difficult to speak about quality of care. And in assuming a responsibility for an increasing number of people to whom we deliver care and delivering care using a mission which we never had before, in lieu of hospitalization or to obviate the need for hospitalization we then began to make approaches to render this care. Was it reasonable and good care?

And I briefly tried to speak to that in the work that you also alluded to, sir, the work that Jerry Charles is doing at San Francisco and is being done in other places. The physician likes to talk about quality of care by looking specifically at to whom he is delivering

care, who is rendering the care, and the resources that are utilized to do that, and what is that cost and is it a reasonable cost.

In the VA we have had very few places to look for any answers. What we are doing within our own system is comparing our system with the other systems at our universities. What we are finding now is if we do what Dr. Bickers has suggested, we define our population and their needs, and then we design a system to care for him. At least in Dr. Charles' and Dr. Inui's group at Seattle, they are now providing care for this population at a cost not greater than and usually less than that in the National Ambulatory Care Surveys.

And we feel that the care there is fully justified and has high quality with peer review and the other internal review mechanisms which are performed by the medical staff.

Chairman SIMPSON. Let me ask you to what extent the quality of services rendered and the amount of the wait time varies? Does that change according to geographical areas in the various VA outpatient clinics?

Dr. BAKER. I think the wait times you'll find, sir, vary greatly among the various aspects of outpatient care. Wait time, at least at Little Rock, tends to be a little longer in the walk-in area than it does in a very tightly run and efficiently managed outpatient clinic where scheduled visits are accomplished.

Chairman SIMPSON. Am I correct in saying that the size of the total hospital staff is dependent upon the size and the level of activity of that hospital's inpatient service? And if so, is that the most effective way of staffing an outpatient service?

Dr. BAKER. We staff our outpatient service in two ways: We have those physicians who largely deliver outpatient care and the primary care which I have talked about. They have a very low hospital readmission rate. The remainder of the hospital staff delivers both inpatient and outpatient care. And I see that as the most efficacious way for a consultant to deliver care in a VA medical center.

I don't like to think about an outpatient staff and an inpatient staff because that brings up the nightmares that I used to have in the early 1970's.

Chairman SIMPSON. You had nightmares?

Dr. BAKER. Yes, sir.

Chairman SIMPSON. Well, we'll go into that at another—no, it seems to me that we are setting this staff level on inpatient services and then I am wondering if that is the effective way to staff the outpatient clinics.

Dr. Baker, in your remarks you talked about a profile of the veteran. And it's a sensitive area that I want to ask this question. It's not done to be dramatic, but it keeps coming up. In that profile, and you mentioned Durham and that has come to my attention before, how many are within the large non-service-connected care area—and you say 70 percent, that's not correct?

Dr. BAKER. Of the 100 we see each day 70 percent will be non-service-connected, that's correct, sir.

Chairman SIMPSON. Right. And how many within that spectrum are being treated for alcohol related problems or first and second diagnosis of alcoholism or alcohol related problems?

Dr. BAKER. Of the 100 walk-ins that we see each day each person is first a candidate for hospital care, because we always approach the sickest patients in the room first. Of the 100 patients we see each day 40 percent are admitted to the hospital. In that group which is admitted to the hospital, which is about 40 patients per day, half of those will be alcohol related problems.

Chairman SIMPSON. I would like your comment on that, Dr. Bickers and Dr. Houston. Your figures.

Dr. BICKERS. My figures would be that somewhere 30 and 40 percent. And I would think that sum on the conservative side. Of the veterans that we see in the nonservice—or the veterans that we see in the whole population, for that matter. And that about 30 to 40 percent of those patients have alcohol related problems. And that is a direct factor or directly effects their being there for care. And that's quite high.

Chairman SIMPSON. Dr. Houston.

Dr. HOUSTON. I'm working in a situation I would think is about 50/50; 50 NSC, 50 SC. It's somewhere around there. And I would think that perhaps our rate was somewhat lower than that in terms of the total relation to alcohol.

Chairman SIMPSON. But you would indicate that is a serious problem among the non-service-connected veteran population seeking hospital care?

You're nodding.

Dr. HOUSTON. Well, you know, nonservice and service connected both do the same things.

Chairman SIMPSON. Oh, yes. I am aware of that, yes. But it is a serious problem——

Dr. HOUSTON. It is a serious problem, yes.

Chairman SIMPSON. Within the VA system as to that kind of care?

Dr. BICKERS. It creates a great deal of expenditure for the care.

Dr. BAKER. It is a serious problem for the people that we serve and it is also a serious problem for the staff to be a concerned person and to try to meet needs in these areas of serious behavioral problems consumes a lot of energy.

Chairman SIMPSON. Yes, and then did your staff have to find their training going into detoxification, Alcohol Anonymous assistance, and that kind of thing? That is a very important part of staff use, is it not?

Dr. BAKER. Yes, sir. Without the alcohol treatment units I think we would be doing this very poorly. Or trying to ignore it.

Chairman SIMPSON. You're what?

Dr. BAKER. Or trying to ignore it.

Chairman SIMPSON. Just a couple more questions. What is the average veterans perception of his eligibility when he comes to the VA hospital? Please, just quickly.

Dr. HOUSTON. I really don't think he has a very comprehensive idea of what he is eligible for.

Chairman SIMPSON. And then you explain——

Dr. HOUSTON. Very often this leads to little PR problems and confrontations.

Chairman SIMPSON. And then after you explain it to him, do you find that many of them are irritated or think that they should

have had a different kind of care or total care regardless of their length of service or whether they are service connected or nonservice connected? They are just saying, "Here I am and you treat me, and it doesn't matter whether I have served this length of time or what kind of disability, I'm a veteran."

Dr. HOUSTON. Some have animosity and some don't. I couldn't percentagewise. This I have found in explaining to the various veterans, some accept it very well, others are very hostile.

Chairman SIMPSON. Well, in defining eligibility and priorities and so on, is it any more understandable than it sometimes is to the staff?

Dr. HOUSTON. In my particular situation I would have to say that my staff is very well versed in priority situations. And from the time they come to the front desk, which I consider very important, to the time they get to the physician, after triage and otherwise, they have been pretty well schooled in what they are eligible for and what they are not eligible for and what they can expect. And they receive it, when explained to them, they receive it very well. To turn them out they probably would be more hostile.

Chairman SIMPSON. Do you have any comment on that, Dr. Bickers?

Dr. BICKERS. I perceive that the veteran is not well informed at all as to his benefits. And he presents himself and says, "Here I am, I am ill." "I defended my country and I expect care." A small percentage of them, fortunately it's a small percentage, becomes hostile and write their Congressmen or Senators concerning the issue as an ultimate resort.

Chairman SIMPSON. I get a lot of letters myself.

Dr. BICKERS. Yes. Yes.

Chairman SIMPSON. On every subject.

Dr. BICKERS. Yes, I'm sure you do.

Chairman SIMPSON. Yes. Yes. Go ahead.

Dr. BICKERS. But only a few of them become as mad as a wet hen, you might say. They do expect a great deal. They do not understand.

Chairman SIMPSON. And are they sensitive when you ask them questions about their eligibility or their service or anything like that in any part of the inquiry?

Dr. BICKERS. Yes. A number of them are. I think one has to take this veteran though in the light of this whole population characteristics which have been well outlined in the National Academy of Sciences study that was turned in in 1977 and made public then, and realize that from a socio and economic standpoint these veterans are seemingly in many instances beaten down and this sort of thing. And they, you know, don't voice a lot of anger. It's only a small percentage that do.

Chairman SIMPSON. Do you have any comment on that, Dr. Baker?

Dr. BAKER. We are unanimous that the veteran is probably the poorest informed categorical group that I have ever been around. You know, most of us don't understand our health insurance policies very well but we have some notion about what they represent and can gain that information pretty quickly before we find our-

selves in the position of being unprotected. The veteran is very poorly informed.

Five years ago Dr. Walt Whitcomb at Oklahoma came to Arkansas and suggested that the first goal for our patient education programs which we were establishing would be helping the veteran to become better informed concerning his entitlement with the Veterans' Administration. I think it was an excellent suggestion.

Chairman SIMPSON. And yet we spend a great deal of money in the VA on outreach and information. I mean, extraordinary projects, obviously not too effective, are they?

Dr. BAKER. That's right.

Dr. HOUSTON. That doesn't all lie with the VA.

Chairman SIMPSON. No, no.

Dr. HOUSTON. Because I am in a retirement area and many of these people belong to the Armed Forces. And they come in with disability discharges not knowing that it has to be adjudicated by the VA before it is acceptable. They have no idea. You know, I am disabled, I have a pension or something from the armed services, I want service here. And when you explain it to them sometimes they get a little uppity. But therefore, the VA has to explain this to them, or we do in our clinic, have to explain this to them. And advise them as to who to see and what to do about the thing.

So I think sometimes coming out of the Armed Forces they aren't very well—it hasn't been elucidated.

Chairman SIMPSON. Let me ask you a couple more. Can you explain to me the rationale between the scheduling of multiple outpatient clinic appointments on different days for the same veteran? Is that done for the convenience of the veteran or good medical practice, or to have a reflection of a higher number of patient visits?

I see you smiling, all three of you. Let the record show, a wry smile.

Dr. BICKERS. Senator Simpson, it has to do more with the inability to gather and maintain accurate information. We by and large are doing that by hand and not by computers. And we deal, for instance, at the Memphis VA Medical Center with approximately 150,000 to 160,000 outpatient visits per year. And when one is doing that for numerous clinics and you have only a small cadre of people and only a defined area to do that, it is very difficult, if not impossible, to do that.

We hope that with the coming of computers and its application to the health-care delivery system which we very much have needed for a number of years, and one of the highest priorities that the VA has is establishing centralized scheduling on this computer system, that this will be able to be done in a matter of seconds.

The veteran, amazingly to me, does not usually voice any disapproval, any more so than I do when I go to the doctor or take my child by coming back on a Wednesday or a Thursday or a Friday or this sort of thing. And it is amazing to me because they might make two or three trips even in 1 week. They are not out to fleece the system or to get money; they simply are doing as they are told.

Chairman SIMPSON. I know that they are not. That's what I am asking about, is anyone?

Dr. BICKERS. We have made attempts at Memphis to do this but it requires a significant number of man-hours to do this. And it is

just very difficult to do within the resources allocated and the manpower that we have to do it.

I have personally been involved with this because this is a real touchy issue with me, and it is one that would save and would be very cost effective compared to what we do now. But it is just very, very difficult to do. And with the computer I think it can be done. It can be done with aplomb.

Dr. HOUSTON. I don't have that problem because I am a satellite clinic and not associated with that type of a physical setup. I have just general practitioners. And I have an excellent staff that can handle quite a few things.

Dr. BAKER. Here's the solution. The reason for multiple clinics are multiple. But one is that most patients are not followed by primary care providers. Most patients are followed by three consultants. The three consultants are not available every day. Now the urologist may be available on Wednesday, while the cardiologist is available only on Fridays, while the hematologist is available on Tuesday. If he's got leukemia, heart disease and has been operated on recently by the urologist he has to see three different people on three different days.

The delivery of primary care or the coordination of that care so that he sees consultants infrequently will hold that problem. My favorite topic. I'm so glad you asked the question.

Chairman SIMPSON. You were fully prepared for that, weren't you.

Dr. HOUSTON. Yes.

Chairman SIMPSON. Let me just ask, and I won't take much longer I promise. I keep saying I am going to quit but I haven't. But another thing that has intrigued me is the medical affiliation benefits, the benefits of medical affiliation, medical school affiliations with regard to the outpatient health-care system. How do you feel, the three of you, as workers in the vineyard, how do you feel about medical school affiliations? How do they impact on the VA outpatient health-care system? How valid are they? And is their cost worth it?

Some of your swift, brief comments on that, please.

Dr. BAKER. Want me to start here and go down?

Chairman SIMPSON. Yes, if you would.

Dr. BAKER. The affiliation is desirable. There is a fine—and this varies—there is a fine marriage between the University of Arkansas and the VA. And the affiliation strengthens both institutions I think there is much to be said for it.

The VA, however, is playing a major role in making the emphasis for our university that the need for outpatient care and outpatient training is essential to present modern day training programs. And it is the need for long term care, and part of that care delivered in the outpatient area with other spectrums of care, which I think is an example of the happy marriage. This should be taught. It is not a sufficiently popular thing yet with universities, but it is so practical and the way things should go that at Little Rock the VA is where the chronic disease is seen. We are leading the way and the university will follow.

The consulting services which the university offer us and the modes of care and the demonstration of good patient care on a long term basis creates a very fine environment.

Chairman SIMPSON. Please, Doctor.

Dr. BICKERS. Memphis VA Medical Center would not be able to deliver the care that it delivers to the quantities of veterans that it has without the close association with the university. Also, the quality of care is greatly enhanced being associated with an academic situation, in my opinion.

It seems to me there is a disadvantage with this association, and that has to do with the curriculum and the training aspects of the student at the university or the resident, if you will. And that is the idea of continuity of care which I addressed in my treatise, in my written statement, which I feel is extremely important and one which has been very difficult for the VA to get at and to acheive.

It's been more difficult, it's even more difficult for university and teaching and training to acheive. And that is a dilemma. It is very difficult. You have residents rotating in various services or various areas for their training which is very necessary for them to become qualitative physicians. And yet, there is a real need for this kind of continuity of care that Rodney spoke of just a moment ago by way of primary care.

And I don't know how to solve that dilemma yet, but I would like very much to work on it.

Chairman SIMPSON. Thank you.

Did you have a question?

Dr. HOUSTON. I agree fully. I think the quality of care for the veterans has improved with the association. The comprehensive care for the veteran has gradually tried to be implemented between inpatient and outpatient, meaning that a patient being cared for by a certain resident on the floor tries to follow him out, tries him when he gets into the outpatient department in order to make some cohesive treatment.

This is being implemented throughout the systems, I feel. They also, it is now necessary to pass your internal medicine boards, you must have a quarter of your time in outpatient services. So these people are interested in performing this.

The thing that I find difficult—and I must say with my present affiliation it is super, just excellent—is to get a patient into the hospital sometimes they're the resident. And right now I deal one-on-one with a man who has been out in the world, he is now with the VA, he has had a history of private practice, he has an empathy for my position, he has an empathy for the veteran's position, he understands the total picture in most cases of what we are faced with with the veteran, not only a sickness but perhaps other aspects of the socioeconomic situations. And so that has made for a really good relationship plus a good thing for the veteran.

I think that when you are working as I do in the logistically difficult situation 125 miles away and transportation being the problem that it is, this is so important.

Chairman SIMPSON. I thank you and appreciate your views, those are helpful to us. I think we have a serious thing to address when we look at this veterans' population as it grows very swiftly into the 65-year category. Millions are involved. The care is a more in-

tensive care than ever required with the others and perhaps requires additional construction and geriatric care. And then we prepare for that and when that hump passes we have some problems, I think.

I think we will provide for the burst as we always have for the veteran population of this country, with a $26 billion budget. I think we do that quite adequately. But what do we do when that passes and we have taken care of them and we have provided and perhaps overconstructed. Some of those problens need to be addressed.

And I thank you, you have presented some provocative things for us. Thank you very much.

Dr. BICKERS. Thank you, sir.

Dr. HOUSTON. Thank you, sir.

Chairman SIMPSON. Next, the veterans' groups. We have John Sommer of the American Legion, the deputy director of National Veterans' Affairs and Rehabilitation Commission, accompanied by Paul Egan, deputy director of the National Legislative Commission of the American Legion; and Don Schwab, director of the National Legislative Service of the Veterans of Foreign Wars of the United States; and Gabe Brinsky, national service and legislative director, accompanied by Peter Currier, deputy national service and legislative director of AMVETS.

Good to see you, gentlemen, and nice to have you here this morning. If you will proceed in that order knowing the time limitations, I would appreciate it.

TESTIMONY OF A PANEL OF REPRESENTATIVES OF VETERANS' ORGANIZATIONS CONSISTING OF: JOHN F. SOMMER, JR., DEPUTY DIRECTOR OF NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION, ACCOMPANIED BY PAUL S. EGAN, DEPUTY DIRECTOR OF THE NATIONAL LEGISLATIVE COMMISSION; DONALD H. SCHWAB, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES; AND GABRIEL P. BRINSKY, NATIONAL SERVICE AND LEGISLATIVE DIRECTOR, AMVETS, ACCOMPANIED BY PETER B. CURRIER, DEPUTY NATIONAL SERVICE AND LEGISLATIVE DIRECTOR

Mr. SOMMER. Thank you, Mr. Chairman. My name is John Sommer, deputy director of the National Veterans' Affairs and Rehabilitation Commission of the American Legion.

Mr. Chairman, the Legion appreciates this opportunity to present our views on VA outpatient health care. We are aware of and sensitive to the demand for services that is being made upon the VA by the veteran population. The demographics of this veteran population make it evident that the need for provision of services is not going to diminish in the foreseeable future, given a continuing commitment by the Government to the provision of health care to veterans with service-connected disabilities, and those veterans who by reason of economic circumstances find it necessary to turn to the VA for health care.

The Legion is committed to the appropriateness and the justification for the present VA medical care program. In our judgment it

must be supported, maintained, and expanded as necessary to fulfill its fourfold mission.

It has been proven that ambulatory care is more cost effective than inpatient care both in the private sector and the VA. Public Law 93-82 opened up a whole new approach to health-care delivery for VA by expanding the outpatient care program which resulted in provision of better care to an increasing number of veterans who need and apply for such care.

There are problems with this program as site reports prepared by our field service representatives consistently indicate that VA outpatient clinics are crowded at all times during the regular business day. Many of them are crowded beyond their capacity to handle their case loads. Most of these problems result from limited resources due to inadequate funding.

With regard to the demographic trends currently impacting on the veteran population, increasing numbers of veterans are moving southward, as has been mentioned earlier. Older veterans to spend their retirement years, and younger veterans because of employment opportunities. These changes have resulted in an increasing amount of pressure on VA facilities in the Sun Belt States.

The impact of this veteran migration on VA health care facilities in Florida has been massive. These facilities are carrying patient loads they were never designed to accommodate. The Federal Government has to face up to the facts and make adjustments accordingly. The same situation prevails in other Southern States.

Another matter of importance to the Legion is the provision of over-the-counter drugs and beneficiary travel. In recent years both OMB and Congress have addressed this matter with express concern. Admittedly, the cost factors for these two services have risen steadily. The reaction has been to try to limit these cost factors and to urge the VA to exercise greater control. The position of the American Legion is that strict management control is definitely indicated.

What the Legion would like for Congress to do is to require and maintain oversight of VA efforts to closely manage these costs. Within that framework, we believe that the funds must be provided if VA is to carry out its mission. In the case of both over-the-counter drugs and beneficiary travel, cost effectiveness must be accompanied by compassion for those most in need of the medicines and who have the most difficulty with public transportation, which are the poorest of the VA's constituency.

In conclusion, we believe that what is needed now is for Congress to mandate a study by an appropriate authority possessing the necessary expertise of the current and anticipated demographic profile of the veteran population and the present capacity of VA to provide medical services to that population in its ambulatory care program. The study should identify the amount and location of resources and how these need to be modified now and for the foreseeable future to meet the demands.

We understand that such a study may result in a reorganization of the Department of Medicine and Surgery's field operations. If such a reorganization needs to be done then it should be done, and the sooner the better, as it is essential for the VA to prepare itself to care for its clientele in the future. The Legion is sure that a re-

organization of VA's health-care delivery system to maximize ambulatory care, thus reserving inpatient care for those who need it, is a cost effective way for VA to fulfill its mission.

Mr. Chairman, that concludes my summary.

Chairman SIMPSON. Thank you very much, Mr. Sommer.

[The prepared statement of John F. Sommer, Jr., deputy director, national veterans' affairs and rehabilitation commission, the American Legion, and the American Legion's response to written questions submitted by Hon. Alan K. Simpson, chairman of the Senate Committee on Veterans' Affairs, follow:]

PREPARED STATEMENT OF JOHN F. SOMMER, JR., DEPUTY DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. Chairman and Members of the Committee:

The American Legion appreciates the opportunity to present its views on the subject of the Ambulatory Care Program of the Veterans Administration Department of Medicine and Surgery.

What we can present to the Committee at this time is a series of perceptions of the Ambulatory Care Program as we have them through reports of our Field Representatives who regularly visit VA installations, and whose reports are provided this Committee, and which we commend to perusal, for the reason that they always include an assessment of the Ambulatory Care Program at the installations visited; and through information received from American Legion Service Officers and other members of our organization who are active in support of the patients in the VA health care program. Our perceptions can only be supplemental to the more precise data provided to the Committee by the VA itself.

The American Legion is aware of and sensitive to the demand for services that is being made upon the VA by a veteran population, in which the largest segment - that of World War II is now in its sixties, and which has been lately increased by the addition of the 9.5 million Americans who served during the Vietnam Era. The demographics of the veteran population make it obviously evident that the need for provision of services is not going to diminish for the foreseeable future, given a continuing commitment by the

Government to the provision of health care to that part of the veteran population that has service-connected disabilities, and that part that, by reason of economic circumstances finds it necessary to turn to VA for health care, in preference to accepting public charity.

We do not believe it is necessary in this statement to present again the philosophical rationale that supports the VA medical care program for veterans as we have it today. That rationale is well understood by all those involved in this hearing. Suffice it to say at this time that The American Legion is categorically committed to the appropriateness, and the justification for the present VA medical care program. In our judgment it must be supported, maintained and expanded as necessary to fulfill its fourfold mission: 1) to provide medical care for sick and disabled veterans; 2) to participate in health manpower training for the nation; 3) to participate in basic research; and, 4) to act as the principal contingency back-up resource to the military medical care program in case of national emergency. This fourfold mission has been legislatively defined, and by reason of that legislative definition, it constitutes the VA medical care program as an essential element of health care delivery to the American people.

The VA Ambulatory Care Program as it is today is essentially the result of action taken by Congress in Public Law 93-82, the Veterans Health Care Expansion Act of 1973. PL 93-82 modified section 612 of title 38, United States Code, to authorize the

Administrator to "furnish medical services for any disability on an outpatient or ambulatory basis -

(1) to any veteran eligible for hospital care under section 610 of this title (A) where such services are reasonably necessary in preparation for, or (to the extent that the facilities are available) to obviate the need of, hospital admission, or (B) where such a veteran has been furnished hospital care and such medical services are reasonably necessary to complete treatment incident to such hospital care (for a period not in excess of twelve months after discharge from in-hospital treatment, except where the Administrator finds that a longer period is required by virtue of the disability being treated);

(2) to any veteran who has a service-connected disability rated at 50 per centum or more; and

(3) to any veteran who is a former prisoner-of-war."

The last available Report of the Administrator of Veterans Affairs, the Report for Fiscal Year 1980, shows that during that year, VA operated 226 outpatient clinics, in which it provided 15.8 million visits, in addition to 2.2 million visits made to private physicians authorized on a fee-for-service basis.

In his Budget Message to the Congress in February 1982, the President requested funding for 18 million outpatient visits for Fiscal Year 1983. This projected increase indicates the increasing level of demand for service being made by the enlarged and aging veteran population.

The site visit reports of American Legion Field Representatives consistently indicate that VA outpatient clinics are crowded at all

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times during a regular business day. Many of them are crowded beyond their capacity to handle their case loads. Their facilities are, in many instances overburdened both as to space, equipment and staff. From time to time we receive horror stories of sick veterans who wait in hallways for long hours before they are seen and cared for by overworked staff. We hear of patients who go all day without food, and sometimes without availability of lavatory facilities. Sometimes these incidents can be ascribed to staff errors - but many times they are simply due to over-burdened resources. When The American Legion learns of such incidents it invariably complains to Central Office and attempts to have the problems corrected. And sometimes VA can correct the problems and sometimes it can't. Resources can only be extended so far. But, we will say to this Committee at this time that there are serious problems in the VA Ambulatory Care Program - mostly resulting from limited resources due to inadequate funding.

The essence of the matter here is that it is a proven fact that ambulatory care is more cost-effective than in-patient care. That is the trend clearly established in the private sector, which through its clinics and emergency rooms is doing more and more health care delivery on an outpatient basis in an increasing effort to control the rapidly escalating costs of health care delivery. What is true for the private sector is equally true for VA. In its Report for FY 1980, VA says: An increasing number of therapeutic procedures also are performed in ambulatory settings, including moderately complex surgery, cancer chemotherapy, and

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the treatment of mental illness. The simple fact is that it is much more economical to treat a patient on an outpatient basis than to admit him to a hospital. This was the forward thinking that led the Congress, through its Veterans Affairs Committees, and with the support of The American Legion to develop the language quoted above in PL 93-82. That law opened up a whole new approach to health care delivery for VA. The new direction has resulted in provision of better care to an ever-increasing number of veterans who need and apply for such care. The problem has developed from the failure to adequately fund this innovative approach to the practice of medicine. But, the point is that regardless of how much the cost of the VA Ambulatory Care Program has escalated, that cost has been far less than would have been incurred without the Ambulatory Care Program, which would have resulted in the hospitalization of multiple thousands more sick and disabled veterans. In this context, it must be borne in mind also, that the escalating cost of ambulatory care in VA simply mirrors the experience of the private sector during a series of years marked by rapidly expanding inflation that in 1980 raged at a level of almost 13 percent.

Having laid this basis for American Legion support for the VA Ambulatory Care Program, we shall now comment on the demographic trends presently impacting on the veteran population. As with the population generally, the trend, of course, is toward the Sunbelt. The demographic profile of the veteran population is rapidly changing as increasing numbers of mostly older veterans move southward to spend their retirement years. However, it

must be said that younger veterans are also moving south in increasing numbers as industry and commerce moves in that direction from the Midwest and Northeast.

The result of these changes is an increasing amount of pressure on VA facilities in the Sunbelt states. The classic example is Florida which is experiencing an increase in its, mostly older veteran population ranging to 7,000 per month. The impact of this veteran migration on VA health care facilities in Florida has been massive. We do not need to quote the statistics here, or spend time describing the details of what is happening. That information is readily available to the Committee from VA itself. The American Legion is very much involved. In the first place, our membership in Florida increases each year. And secondly, our Service Officers are called on to assist veterans to the VA resources where they can obtain the health care services they need.

Without exception, the VA health care facilities in Florida are carrying patient loads they were never designed to accommodate. The Federal Government has to face up to that fact and make adjustments accordingly. It is our understanding a new clinic is in the process of being opened in the Fort Lauderdale area. There is a new clinic in Broward County, north of Miami. Other things are being done - but not enough is being done. Much more needs to be done if VA is to meet its responsibilities to the veteran population in Florida. And that same situation prevails in other southern areas of the nation. An American Legion Field Representative

completed a site visit to VAMC Little Rock, Arkansas in March of this year. He ascertained that the Ambulatory Care Program at Little Rock VAMC recorded 161,729 visits during FY 1981. In FY 1982, through February, the clinics recorded 64,349 visits. The simple fact is that in such places as Florida, Arkansas, Arizona, some parts of Texas, and other places in the Sunbelt, the volume of demand for services is increasing in multiples. Our perception is that VA is not ready for this influx of veterans. It is trying, and doing its best with the resources available, but these resources need to be increased - in a major way, and rapidly. We shall make a recommendation in that regard in a moment.

First, let us comment on a matter mentioned in the Chairman's letter to The American Legion, dated May 28, 1982, and inviting our organization to present its views at this time. In his letter, the Chairman raised the question of an increasing demand for services by women veterans, and whether adjustments need be made in the system to accommodate this demand.

It is true there are an increasing number of women serving in the All-Volunteer Armed Forces. At some time in the future these women may constitute a measurable element of the VA clientele. Presently, we of the Legion cannot evaluate the dimensions of the need that may develop. We are not aware that women veterans are impacting the system currently, in a significant manner. We doubt that adjustments in staffing and facilities are now needed. It appears to us the most cost-effective way to provide services to women veterans continues to be on a contract basis for specialized

services. Other than that, present facilities would seem to be adequate for women, with the obvious stipulation that resources generally are in fact presently inadequate to meet overall demand.

Another matter mentioned in the Chairman's letter, and one to which the Legion attaches major importance, is that of provision of over-the-counter drugs and beneficiary travel. With regularity in recent years, both OMB and Congress have addressed this matter with express concern. Admittedly, the cost factors for these two services have risen steadily. The reaction in Government has been to try to limit these cost factors and to urge VA to exercise greater control. The position of The American Legion is that strict management control is definitely indicated. Without management control these particular factors do tend to get out of hand. However, the collateral point to be made is that these services - over-the-counter drugs and beneficiary travel are mainly provided to the poorest and the oldest of the VA clientele. It is an established fact that the cost of medicine is one of the most important elements of the cost of living of older people. They need more medicines, and with the inflated cost of pharmaceuticals it is hard for them to meet this cost. In this area they need help, and so, those who are veterans turn to VA. Where else are they to go? The same applies to beneficiary travel. Surveys show the most frequent applicants for travel allowances are those who are poorest and most feeble, and who have most difficulty with public transportation. VA must respond to this.

What The American Legion would like Congress to do, is to require and maintain oversight of VA efforts to closely manage

these costs. Within that framework, we believe the funds must be provided if VA is to carry out its mission. In the case of both over-the-counter drugs and beneficiary travel, what we wish to say to the Committee is that cost-effectiveness must be accompanied by compassion for the poorest and the oldest of the VA's constituency.

Now, Mr. Chairman, and Members of the Committee, we come to just what The American Legion believes should be done about the VA Ambulatory Care Program. We believe those who wrote and enacted Public Law 93-82 were far-sighted. The problems foreseen in that legislation are now clearly evident. There is now an aging veteran population, migrating southward and in need of an increasing level of health care services. The legislators also providently foresaw that ambulatory care would be more cost-effective than any effort to continue to expand the hospital system and continue to provide more and more beds. Since enactment of PL 93-82 VA has eliminated upward of 25,000 beds from its system. We hasten to observe we of the Legion believe these reductions have been too great. Aside from ambulatory care, the Government must face the fact that the older veterans will begin to experience an increasing number of acute episodes of catastrophic illnesses that will require in-patient care. Only in hospital beds can that care be provided. We believe Congress recognized that fact in the language of Public Law 97-72, the Veterans' Health Care, Training, and Small Business Loan Act of 1981, wherein, in Section 108, Congress mandated VA to: establish the total number of hospital beds and nursing home beds in medical facilities over which the Administrator has direct

jurisdiction for the care and treatment of eligible veterans at not more than one hundred twenty-five thousand and not less than one hundred thousand. The American Legion strongly supported that language in PL 97-72.

Having made that point, we move on to the Ambulatory Care Program. The American Legion believes what is needed now is for Congress to mandate a study by an appropriate authority, possessing the necessary expertise, of the current and anticipated demographic profile of the veteran population, and the present capacity of VA to provide medical services to that population in its Ambulatory Care Program. We believe the study should identify the amount and location of resources, and how these need to be modified now and for the foreseeable future to meet demands. For example, if the older veteran population is migrating southward - which it is - then it seems clear that greater resources must be allocated to that part of the nation, and concomitantly there should be a moderation of demand for services in some other parts of the country. This study, simply defined in this statement, would, of course, be complex and detailed in its findings. It might result in major readjustments within the VA Department of Medicine and Surgery. We are aware that VA is in fact undertaking certain studies of its own that might add to the fund of knowledge needed on this subject of ambulatory care. However, it is our suggestion that Congress should perhaps not rely entirely on VA to carry out such a study, but should add to the VA's effort, information that it obtains through its legislative authority, independently arrived at, and

providing guidance as to where funding should be directed, and what and where resources should be acquired, to enable VA to meet its legislatively defined mission.

The American Legion categorically supports the fourfold mission of the Veterans Administration in the field of health care, as that mission is presently legislatively stated. We further accept what appears to be fact, that ambulatory care, in individual cases is better for the patient, and cost-effective for the provider. That fact is now accepted by medical science for both the public and private sectors. We understand that a study such as we here suggest may result in a reorganization of VA's Department of Medicine and Surgery in its field operations. If a reorganization needs to be done, then it should be done, and the sooner the better. It is essential now, for the Veterans Administration to prepare itself to care for its clientele for the balance of the Twentieth Century and into the next Century.

The American Legion is sure that a reorganization of VA's health care delivery system to maximize ambulatory care, thus reserving in-patient care for those who need it, is a cost-effective way for VA to fulfill its mission. The cost of the Ambulatory Care Program will no doubt increase. But the savings will be immediately realized in restrained demand on bed services within the VA system.

Mr. Chairman, and Members of the Committee, we commend the observations in this statement to the serious consideration of the Committee, and, finally, we urge that time, indeed is of the essence in this important matter.

We thank the Committee for receiving our views.

RESPONSE OF THE AMERICAN LEGION TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN K. SIMPSON, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1. Do you believe that VA outpatient eligibility standards are being fairly and uniformly applied throughout the VA health care system?

Answer 1. The policy is the same for outpatient and inpatient benefits. Management can only operate within the constraints of their local budget. So far as we are able to determine the eligibility standards are being applied as equitably as possible.

Question 2. Do you believe these standards are inappropriate? If so, how would you change them?

Answer 2. The standards are appropriate for treatment purposes. When the demand is greater than local resources, management will restrict treatment according to the category guidelines. Any additional changes would have to be implemented by legislation.

Question 3. How would you rate the quality of care being provided in the VA outpatient health care system?

Answer 3. The quality of care overall is good. However, it suffers from budgetary and legislative restrictions in that treatment of nonservice-connected veterans is limited. It would require more space, more staff, and larger supportive budgets to fully treat all veterans in need of care.

Question 4. How effective is the initial health screening process that is conducted for nonservice-connected veterans before outpatient health care treatment is administered?

Answer 4. An added question - Should eligibility be stricter for outpatients? If eligibility is further restricted, costs will become greater due to the added restrictions on treatment on an ambulatory care basis. If added restrictions prevail, the veteran will wait until condition worsens and then the veteran will have to be hospitalized at a greater expense than if his condition was treated on an outpatient basis.

Question 5. Do you believe that referrals of nonservice-connected veterans by the VA to community health service are generally appropriate, effective and standard throughout the country.

Answer 5. The veteran is referred because he is not eligible for treatment in the VA. It would be better for continuity of care if they had the eligibility and the system had the resources to provide medical treatment for them. Furthermore, all communities do not have available treatment centers. Those that do are also under budget restrictions and the availability and quality of care varies greatly.

Question 6. Do you have suggestions concerning the VA's practice of scheduling multiple clinic visits on separate days instead of on a single day in many cases?

Answer 6. Multiple clinic visits for examinations and treatment cannot always be scheduled on the same day. It depends on the circumstances of the local facility, the availability of physicians and the number of veterans scheduled to that specific clinic on any given day. As a rule, there is no excuse not to schedule appropriate exams on the same day. This could be done with computer control.

Question 7. What is the impact of medical school affiliations on the VA outpatient health care system?

Answer 7. Generally, the admitting area is staffed by VA physicians. The VA physician has been providing this service for a long time. The medical resident elects that he needs the outpatient experience. The residents may schedule some veterans back three or more additional times if interested in a certain type of medical problem. The resident by and large does not have the expertise or tact to administer treatment to veteran outpatients.

Affliated hospitals utilize residents for post-hospital care. This gives continuity of care. For the most part, the care is good. With proper scheduling and adequate space, this works well.

Added response - The Ambulatory Care Section must set up a review process of case files on all veterans not admitted for treatment, to determine why they were not admitted. Likewise, case files on veterans admitted also must be reviewed to ensure that good quality care is being provided.

Chairman SIMPSON. And now, Don, please.

Mr. SCHWAB. Thank you for the privilege of appearing here this morning. My name is Donald H. Schwab, and it is my privilege to serve the more than 1.9 million men and women of the Veterans of Foreign Wars as their national legislative director.

Mr. Chairman, it has been the practice of VA Administrators in recent years in defending repeated inadequate budgets for the Veterans' Administration to point out how much that budget has increased over the last 10 years. Well, let us take a closer look at those budgets.

In 1973, the VA budget was $12 billion in outlays or 4.9 percent of the Federal budget of $245.6 billion. Senate Concurrent Resolution 92, as amended and passed by the Senate, establishes for the fiscal year 1983 a VA budget of $23.2 billion in outlays or 2.95 percent of the Federal budget of $784.2 billion. Therefore, while the VA budget has about doubled in the last 10 years, the Federal budget has more than tripled in that same period and the VA budget has fallen 2 percent of the Federal budget in outlays during a period in which the veteran population increased 8.5 million due to the Vietnam conflict.

Now, let us compare VA budgets with those of the human resources program over the past 33 years. In 1950 the VA budget was

$8.8 billion and projected at $23.2 billion in 1983. The budget in 1950 for education, training, and employment and social services was $241 million and for 1983, $21.5 billion. For health in 1950 the budget was $268 million and for 1983, $78.1 billion. And income security has risen from $4.7 billion to $261.7 billion during the same period.

In other words, and as reported in House Veterans' Affairs Committee Print No. 74, "Federal outlays for veterans' benefits and services have increased only threefold compared with 291-fold for health; 89-fold for education, training and social services; and 55-fold for income security." Our wartime veterans, Mr. Chairman, are not the budget busters.

Admittedly, although in the last 10 years that portion of the VA budget for veterans' hospital and medical care has increased from $2.7 billion to a projected $8.1 billion, it has fallen from 13.5 percent of the total Federal budget in outlays for all health care to 9.4 percent and there are now 30 million veterans. Again, veterans are not the ones who will break the bank.

Following in my testimony I listed the veterans' laws that were passed in recent history that expanded outpatient care for both service-connected and non-service-connected veterans, and I will not belabor you with a recitation of those at this point. But the foregoing has been outlined to establish three points at this time, which are: That veterans' benefits and services are not the budget busters. Veterans' health care is not the health program that is going to break the bank.

The intent of Congress has historically been in the last century to provide health care for veterans in need suffering from non-service-connected disabilities, subject to the availability of resources. And the preponderance of legislation in recent history expanding outpatient care have been the outgrowth of the Vietnam conflict, which, as I previously said, increased the veteran population by 8.5 million.

In response to your question in the letter of invitation about the ability of the VA to furnish health care for those veterans who may become eligible, the VA cannot even now provide health care for those who seek such. Outpatient treatment for non-service-connected veterans has fallen from 7.7 million in 1977 to 6.8 million in 1981. This in spite of legislation expanding the eligibility of these veterans.

We know, through our network of service officers across the Nation, that non-service-connected veterans are, and have been, denied outpatient care at VA facilities and referred to community hospitals as welfare cases. To the VFW this is repugnant.

We believe that our veterans in need should be cared for by the VA with dignity and the necessary funding and personnel be made available.

Your letter, Mr. Chairman, indicates the committee is interested in examining the "appropriateness of continuing to provide over-the-counter medicine and beneficiary travel to non-service-connected veterans." These are two areas eliciting high emotional response, as you know. The primary objective of the VFW is to maintain the basic integrity of the VA hospital and medical care system.

Over-the-counter nonprescription drugs, and beneficiary travel are supplements to primary health care. However, if budgetary constraints become so severe that it becomes a choice between making available to direct health care all the funding possible and reducing supplements, or keeping all the supplements and reducing health care, the choice is clear—we must go back to basics.

Unless funding for beneficiary travel, Mr. Chairman, is substantially increased, reimbursement must be restricted, but, by all means it must be done evenhandedly. Special consideration must be given to those veterans in receipt of pension, those who travel great distances or those who, because of great disability or emergency, must use costly ambulance service or taxi service.

Mr. Chairman, this completes my summary statement. I will be happy to respond to any questions you may have.

Chairman SIMPSON. Thank you very much, Don.

[The prepared statement of Donald H. Schwab, director, National Legislative Service, Veterans of Foreign Wars of the United States, and the VFW's response to written questions submitted by Hon. Alan K. Simpson, chairman of the Senate Committee on Veterans' Affairs, follow:]

VETERANS OF FOREIGN WARS OF THE UNITED STATES

OFFICE OF THE DIRECTOR

PREPARED

STATEMENT OF

DONALD H. SCHWAB, DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

WITH RESPECT TO OVERSIGHT OF THE VETERANS
ADMINISTRATION OUTPATIENT HEALTH CARE SYSTEM

WASHINGTON, D. C. JUNE 9, 1982

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

Thank you for the privilege of appearing before this distinguished Committee to present the views of the Veterans of Foreign Wars of the United States.

My name is Donald H. Schwab, and it is my privilege to serve the more than 1.9 million men and women of the Veterans of Foreign Wars as their National Legislative Director.

Mr. Chairman, the VFW is pleased that you are holding this hearing which hopefully will lay to rest the myth that veterans are "budget busters" and re-affirm this nation's commitment to providing health care for our wartime veterans.

It has been the practice of VA Administrators in recent years in defending repeated inadequate budgets to point out how much that budget has increased over

the last ten years. Well, let us take a closer look at those budgets. In 1973, the VA budget was $12 billion in outlays or 4.9 percent of the Federal budget of $245.6 billion. S. Con. Res. 92, as amended and passed by the Senate, establishes for the fiscal year 1983 a VA budget of $23.2 billion in outlays or 2.95 percent of the Federal budget of $784.2 billion. Therefore, while the VA budget has about doubled in ten years, the Federal budget has more than tripled in the same period and the VA budget has fallen off to two percent of the Federal budget; this, while the veteran population increased by 8.5 million. Obviously, veterans are not the "budget busters." Now, let us compare VA budgets with those of the Human Resources Programs over the past 33 years. In 1950, the VA budget was $8.8 billion and projected at $23.2 billion for 1983. The budget in 1950 for Education, Training, Employment and Social Services was $241 million and for 1983, $21.5 billion; for Health in 1950 the budget was $268 million and for 1983, $78.1 billion; and Income Security has risen from $4.7 billion to $261.7 billion during the same period. In other words, and as reported in House Veterans' Affairs Committee Print No. 74, " . . . Federal outlays for veterans' benefits and services have increased only three-fold compared to 291-fold for Health; 89-fold for Education, Training and Social Services; and 55-fold for Income Security." Our wartime veterans, Mr. Chairman, are not the "budget busters." Admittedly, although in the last ten years that portion of the VA budget for veterans' hospital and medical care has increased from $2.7 billion to a projected $8.1 billion, it has fallen from 13.5 percent of total Federal outlays for all health care to 9.4 percent and there are now 30 million veterans. Again, veterans are not the ones who will "break the bank."

Given the foregoing, Mr. Chairman, let me state for the record that by comparison with veterans with non-service-connected disabilities we have en-

countered relatively few problems with respect to veterans with service-connected disabilities receiving treatment in VA facilities. Those cases coming to our attention wherein service-connected veterans have been denied care are normally resolved at the proper level within the VA by our National Veterans Service. The crucial problem is the denial by VA facilities of care to wartime veterans in need and suffering from non-service-connected disabilities, the end result of underfunding and understaffing over a protracted period. The referral of veterans in need of care to community hospitals as welfare patients was never the intent of Congress and abhorrent to the VFW. According to the Veterans Administration, "Before 1924, Congress indirectly provided medical treatment to veterans with non-service-connected disabilities by incorporating the National Home for Disabled Volunteer Soldiers (the 'Home'), Act of March 3, 1865, chap. 91, 13 Stat. 509, as amended by Act of March 21, 1866, chap. 91, 13 Stat. 10, which provided care for its inmates. Initially, the Home's only inmates were soldiers in the Civil War 'who have been or may be totally disabled by wounds received or sickness contracted in the line of their duty.' 13 Stat. 509, 510. Congress required, however, that individuals admitted to the Home's facilities pay any Federal Government pension that they were receiving into the Home's treasury under its rules. Act of August 7, 1882, chap. 433, 22 Stat. 302, 322.

"In 1884, the Home's facilities, however, were made available to 'honorably discharged soldiers and sailors who served in the war of rebellion, volunteer soldiers and sailors of the war (of) eighteen hundred and twelve and of the Mexican War, who are disabled by age, disease, or otherwise, and by reason of such disability are incapable of earning a living.' Act of July 5, 1884, chap. 223 § 5, 23 Stat. 120, 121. In 1887, the Home was made available to all veterans in such circumstances. Act of March 2, 1887, chap. 316, 24 Stat. 444.

In 1930, the functions and facilities of the Home were transferred to the VA."

Mr. Chairman, the longstanding intent of Congress to care for veterans with non-service-connected disabilities is clearly enunciated in paragraph 10, Title II of Public Law 68-242, the "World War Veterans' Act, 1924" which is herein quoted:

"That all hospital facilities under the control and jurisdiction of the bureau shall be available for every honorably discharged veterans of the Spanish-American War, the Philippine Insurrection, the Boxer Rebellion, or the World War suffering from neuropsychiatric or tubercular ailments and diseases paralysis agitans, encephalitis lethargica or amoebic dysentery, or the loss of sight of both eyes regardless whether such ailments or diseases are due to military service or otherwise, including traveling expenses as granted to those receiving compensation and hospitalization under this act. The director is further authorized, so far as he shall find that existing Government facilities permit, to furnish hospitalization and necessary traveling expenses to veterans of any war, military occupation, or military expedition since 1897, not dishonorably discharged without regard to the nature or origin of their disabilities: Provided, That preference to admission to any Government hospital for hospitalization under the provisions of this subdivision shall be given to those veterans who are financially unable to pay for hospitalization and their necessary traveling expenses."

Moving along to more recent history, Mr. Chairman, Public Law 91-500 made a noteworthy change with respect to the treatment of veterans suffering from non-service-connected disabilities. Although cited as "An Act of amend Title 38 of the United States Code to provide that veterans who are 72 years of age or older shall be deemed to be unable to defray the expenses of necessary hospital or

domiciliary care," section 4 thereof amended 38 USC 610 by adding "any veteran for a non-service-connected disability if such veteran is 65 years of age or older."

Mr. Chairman, a landmark change in the scope of care provided by the VA is encompassed in Public Law 93-82, the "Veterans Health Care Expansion Act of 1973." Section 103 amended 38 USC 612(f) to permit the Administrator to furnish medical services for any disability on an outpatient or ambulatory basis "to any veteran eligible for hospital care under section 610 of this title (A) where such services are reasonably necessary in preparation for, or to obviate the need of, hospital admission or (B) where such veteran has been granted hospital care and such medical services are reasonably necessary to complete treatment incident to such hospital care . . . . " The pertinent portion of the legislative history of the law states in part: " . . . presently, such outpatient and ambulatory care for non-service-connected disabilities may be provided only on a pre-hospital or post-hospital care basis or to any war veteran with a total and permanent service-connected disability. The revised subsection (f) includes for the first time the language 'on an outpatient or ambulatory basis' and makes the provision applicable to service-connected as well as non-service-connected disabilities . . . . "

Public Law 94-581, the "Veterans Omnibus Health Care Act of 1976," contains some 19 provisions. The most salient ones are: (1) the authorization of mental health services for family members of service-connected veterans receiving outpatient care when essential to the treatment of the veteran and, at the Administrator's discretion, for the family of a non-service-connected veteran as an outpatient when essential to permit his discharge from the hospital; (2) provides complete health care to any veteran with a service-connected disability rated at 50 percent or more; (3) established outpatient priorities for service-connected

veterans 50 percent or more disabled, those less than 50 percent and non-service-connected veterans with major disabilities; and (4) limits non-service-connected outpatient care to that provided in VA facilities, limits duration of care provided to complete treatement incident to hospital care, limits the provision of care to "obviate" the need for hospital admission to only those circumstances when VA facilities are available.

Mr. Chairman, Public Law 96-22, the "Veterans' Health Care Amendments of 1979," further enhanced the scope of health care furnished by the VA. Title I, among other measures, established a new readjustment counseling and mental health program for Vietnam Era veterans; established a five-year pilot contract program for the treatement and rehabilitation of veterans with drug abuse or alcohol problems; established a five-year pilot program of preventive health care for veterans with service-connected disabilities rated 50 percent or more or those receiving treatment for a service-connected disability; and modified outpatient priorities to include in the third priority examinations for compensation claims. Title II restored authority to expand the circumstances under which veterans would be eligible for contract outpatient treatment (fee-basis care) for non-service-connected disabilities by revising certain restrictions imposed by Public Law 94-581.

The "Veterans' Programs Extension and Improvement Act of 1979," Public Law 96-151, contains provisions to: (1) authorize the VA to provide contract health care for non-service-connected conditions when authorized by a VA physician as necessary for the treatment of a medical emergency; (2) authorizes VA outpatient medical care for World War I veterans, as well as for veterans of the Mexican Border period, on the same basis as for housebound veterans or those in need of aid and attendance and, also, full eligibility for outpatient medical care for a non-service-connected disability to include contract outpatient care under cer-

tain conditions; and (3) authorized the VA to furnish home health services not to exceed $600 per year to housebound veterans or veterans in need of aid and attendance.

Mr. Chairman, two of the laws enacted during the last session of Congress contain provisions increasing health care for veterans.

Public Law 97-37, "Expansion of Eligibility Criteria to Certain Benefits and Health Care for Former Prisoners of War," reduced from six months to 30 days the required period of incarceration for presumption of service-connection relating to disabilities and diseases resulting from malnutrition, psychosis and any of the anxiety states and, also, provides eligibility for hospital and outpatient care to former POWs. For disabilities not determined to be service-connected, it places former POWs in a fourth category for outpatient care ahead of all others with non-service-connected disabilities.

The "Veterans' Health Care, Training and Small Business Loan Act of 1981," Public Law 97-72, made two important changes. First, it provides eligiblity for basic health care services by the VA for a veteran's disability if it is found that the veteran may have been exposed in Vietnam to any toxic substance in a herbicide or defoliant, or to ionizing radiation from the testing of a nuclear device following World War II, if determined by a VA physician or an authorized representative as possibly having resulted from exposure to a herbicide or ionizing radiation. Secondly, the law extended for three years readjustment counseling centers (Vet Centers) for Vietnam Era veterans.

Mr. Chairman, the foregoing has been outlined to establish three points at this time, which are:

1. Veterans' benefits and services are not "budget busters" and veterans health care is not the health program that is going to "break the bank."

2. The intent of Congress has historically been to provide health care for veterans in need suffering from non-service-connected disabilities, subject to the availability of resources, even before there were outpatient facilities.

3. The preponderance of legislation in recent history liberalizing health care for both service-connected and non-service-connected veterans was the outgrowth of the Vietnam conflict which swelled the veteran population by 8.5 million.

Mr. Chairman, in your letter of invitation you requested comment " . . . on the ability of the VA to continue to provide quality outpatient health care for its growing patient demands within present fiscal constraints."

It is a fact, Mr. Chairman, that the VA cannot even now provide care to all of the veterans seeking such suffering from non-service-connected disabilities. According to the VA publication, "Trend Date 1957-1981," outpatient treatment for non-service-connected veterans has fallen from 7.7 million in 1977 to 6.8 million in 1981. This, in spite of legislation expanding the eligibility of these veterans. We know, through our network of Service Officers, that non-service-connected veterans are, and have been, denied outpatient care at VA facilities and referred to community hospitals as welfare cases. To the VFW this is repugnant. We believe our veterans in need should be cared for by the VA with dignity and the necessary funding and personnel made available. Health care for veterans is one of the continuing cost of war and either our government will honor this commitment or renege on it. The President in his original budget proposed to honor it by increasing the VA medical care account by $530 million and 1,167 personnel. S. Con. Res. 92, as amended and passed by the Senate, is considerably better than the original Budget Committee bill, but the addition of $259 million for medical care falls short of the need. The operation of VA outpatient facilities can be compared to the grocer trying to put

six pounds of sugar in a five pound bag -- it simply cannot be done. We of the VFW believe Congress should fully fund the VA medical care budget. Although a large number of veterans will reach age 65 over the next few years, we do not believe they will all inundate the outpatient system. Those who use these facilities most are veterans with service-connected disabilties and the non-service-connected who are in need and reside in close proximity to a VA facility and who have no health insurance. As the VA budget stated in Volume II, " . . . 58 percent of VA patients are below the poverty level of income . . . " and " . . . VA users have lower incomes, are more often not married, are generally older, are more often disabled, and are more often members of minority groups . . . . " Veterans now approaching retirement age are in better financial condition than veterans of prior wars.

In response to another of your questions, Mr. Chairman, the method of outpatient facilities in complying with the priority system established by 38 USC 612 varies according to our Field Representatives. However, all patient folders are appropriately identified by priority. Those of service-connected veterans are placed in one basket and first referred to a physician. Non-service-connected folders are placed in another basket and at this point, priority for treatment is dictated by the workload in each specialty. If the ENT clinic has few referrals, a priority four patient with an eye problem may be seen before a priority three patient waiting to see a very busy physician in internal medicine. However, all facilities strive to adhere to the priorities.

In our opinion, professional personnel in VA outpatient clinics are not sufficiently schooled in geriatrics to fully accomodate the aging veteran population. As previously stated before this and other committees, Congress recognized this growing problem in the passage of legislation which became Public Law 96-330, one provision of which expanded the Geriatric Research and Care Programs. Un-

fortunately, funding for expansion of this program has never been provided.

Mr. Chairman, the VA outpatient system has not been fully responsive to the shift in the veteran population to the sunbelt states, through no real fault of the VA. The phenomena of population shifts is of recent origin and construction planning by the VA involves years to have in place unanticipated needed facilities. In testimony before a field hearing by this Committee held in Phoenix, Arizona last January, our Senior Vice Commander-in-Chief, James R. Currieo, pointed out the problems in his home state. With respect to Florida, I believe the Honorable Daniel A. Mica summed it up quite well when our Commander-in-Chief, Arthur J. Fellwock, testified in March. Mr. Mica stated that 5,000 veterans a month are moving to Florida. Quoting from the hearing transcript he further stated: "We can expect to see a 100 percent increase in the number of veterans in Florida in the next 18 years and a 700 percent increase in their medical needs. The Miami VA outpatient clinic was designed to see 135 people a day. Right now they are seeing 1,000 a day. That needs to be corrected in our veterans' budget.

"The last point that I found out is that in our State, and is is happening around our Nation, in our Miami facility and the West Palm Beach facility, non-service connected veterans are being turned away.

"Illegal aliens go to the hospital across the street and they get instant treatment. That ought to be pointed out.

"Mr. Chairman, I don't begrudge any money to any individual that needs help and care but if we could find $100 million last year in our Federal budget for illegal refugees, then we ought to find a little more for the veteran."

With respect to the growing number of female veterans, Mr. Chairman, sanitary and privacy considerations leave much to be desired in nearly all outpatient facilities. In addition, there is a paucity of physicians who specialize

in obstetrics and gynecology. Medical school affilation reduces the problem at some locations, but the problem continues to exist.

Your letter, Mr. Chairman, indicates the Committee is interested in examining the " . . . appropriateness of continuing to provide over-the-counter medicine and beneficiary travel benefits to non-service-connected veterans." These are two areas eliciting a high emotional response, as you know. The primary objective of the VFW is to maintain the basic integrity of the VA hospital and medical care system. Over-the-counter non-prescription drugs and beneficiary travel are supplements to primary health care. However, if budgetary constraints become so severe that it becomes a choice between making available to direct health care all the funding possible and reducing supplements, or keeping all of the supplements and reducing health care, the choice is clear cut -- we must go back to basics. The funding for drugs and medicines for the VA is projected at $391 million for 1983, up $42 million over 1982. Beneficiary travel at $65.9 million is down $16.9 million from 1982 which at $82.9 million proved inadequate.

If more stringent cost-savings than now envisioned are mandated, we could accept restricting over-the-counter non-prescription drugs for those with non-service-connected disabilities to those in receipt of pension or those for whom the restriction would cause a hardship.

Unless funding for beneficiary travel is substantially increased, which appears unlikely at the moment, such reimbursement must be restricted, but, by all means, even handedly. Special consideration must be given to those veterans in receipt of pension, those who travel great distances and those, who because of great disability or in an emergency, must be transported by costly ambulance service or taxi.

Mr. Chairman, great blame is placed on the ambulatory care program for the large increase in outpatient visits, but many seem to forget that within the same time frame we added 8.5 million veterans of the Vietnam Era to the veteran population of now 30 million. Furthermore, most of those treated are not non-service-connected veterans. In 1981, the total number of outpatient visits was 17.9 million. Of those, 7.3 million were treatment of service-connected veterans; 337.5 thousand were for compensation and pension examinations; 2.4 million were examinations for medical care; 6.8 million were treatment of non-service-connected disabilities; and 907.4 thousand were "all others."

Mr. Chairman, as stated earlier, health care for our nation's veterans is one of the continuing costs of war and wars are costly, in many ways. Since the signing of the Declaration of Independence a little over 200 years ago, the United States has spent more than 40 years, or one-fifth of our time as a nation, engaged in fighting wars. Of the 44.4 million who served in those conflicts, 1.1 million gave their lives and several million were wounded or otherwise disabled. Our veterans are very special, Mr. Chairman, and justly deserve full funding of their medical care program so that no veteran in need must be denied medical care or drugs or travel pay.

This concludes my testimony and I will be happy to respond to any questions you may have. Thank you.

RESPONSE OF THE VETERANS OF FOREIGN WARS OF THE UNITED STATES TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN K. SIMPSON, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1. Do you believe that VA outpatient eligibility standards are being fairly and uniformly applied throughout the VA Health-Care System?

Answer 1. Outpatient eligibility standards as required by 38USC 612 are generally adhered to. There may be some variation from one facility to the other depending largely upon the availability of resources to include professional and nonprofessional staffing of the clinic. Veterans are generally treated in the order of priority.

Question 2. Do you believe these standards are inappropriate? If so, how would you change them?

Answer 2. Although the priorities are not necessarily inappropriate, the requirements for outpatient treatment of nonservice-connected veterans are. There are variations in the policy used in determining the type of disability required for treatment of the nonservice-connected veteran to obviate the need for hospitalization. The determination is normally decided by the medical judgment of the attending physician. This can be detrimental to the veteran in certain instances involving diabetes or hypertension, for example. Stabilization of either of these disabilities may be present at the time of examination but without further treatment, the degree of stabilization may not continue.

It has been noted in some hospitals that a high degree of sensitivity toward the unfortunate veteran being deprived of outpatient care is prevalent among many professional and nonprofessional personnel involved in patient care. Most physicians would prefer to treat all veterans and do feel that follow-up care is essential if any degree of stabilization of the disability is to continue.

Question 3. How would you rate the quality of care being provided in the VA Outpatient Health-Care System?

Answer 3. Quality of care varies from one hospital to the other depending upon the availability of good physicians. Affiliated hospitals usually fair quite well because of the expertise of quality physicians available from the medical school.

Question 4. How effective is the initial health screening process that is conducted for nonservice-connected veterans before outpatient health-care treatment is administered?

Answer 4. In most facilities, screening procedures are conducted in accordance with existing criteria. We do object to the criteria used which denies outpatient treatment to some veterans who do in fact need outpatient care and are referred to medical facilities in the private sector.

Question 5. Do you believe that referrals of nonservice-connected veterans by the VA to community health services are generally appropriate, effective, and standard throughout the country?

Answer 5. Referrals of nonservice-connected veterans by the VA to community health services are not standard and certainly not appropriate and not condoned by the VFW. (See also response to question #2.)

Question 6. Do you have suggestions concerning the VA's practice of scheduling multiple clinic visits on separate days instead of on a single day in many cases?

Answer 6. It would be almost impossible to schedule clinic visits for all specialty clinics on the same day. Physicians specializing in certain fields of medicine are not always available, particularly part-time physicians and consultants. Fiscal and physical constraints and the unavailability of physicians often preclude optimum scheduling of patients.

In a number of facilities, time sharing of clinical space and examining rooms by physicians of different specialties is necessary because of the inadequacy of the physical plant. Adequate funding to permit expansion of physical plants where necessary, to hire additional consultants and physicians would alleviate the necessity of scheduling multiple clinic visits on separate days.

Question 7. What is the impact of medical school affiliations on the VA Outpatient Health-Care System?

Answer 7. The expertise in various fields of medicine would not be available without the service of physicians from medical schools. It might be well to mention that part-time physicians from medical schools (as in the Birmingham VAH where as many as 92 percent were part-time) are essential to the survival of some hospitals.

Chairman SIMPSON. And now Mr. Brinsky. Gabe Brinsky, please.

Mr. BRINSKY. Good morning, Mr. Chairman.

Chairman SIMPSON. Good morning.

Mr. BRINSKY. AMVETS wishes to thank you for the invitation to appear here today.

I have further reduced the statement which I intended to orally deliver for the sake of conserving time. But I do want to orally comment on a subject which is of extreme importance to us. And that is the problem of geriatrics.

In less that 10 years from now 2 out of every 3 males in the United States over the age of 65 will be a veteran. It is projected that in less that 20 years there will be more than 8 million veterans when almost one-third of the veteran population will be over age 65. This is worth pondering as to what it translates into in terms of need for health-care facilities and resources.

In this framework of patient potential we must also accept the fact that older patients require frequent hospital admissions with its longer hospital stays and, of course, more medical attendance by

physicians. It is common knowledge that the older veteran is more likely to develop more complicated illnesses.

Currently there are eight VA geriatric research, education and clinical center programs, which are commonly referred to as GREEC's. This program was initially initiated in 1973. Public Law 97-330 authorized the development of seven additional geriatric centers. One of these was planned for Camden, N.J., which was subsequently scrapped.

We are extremely concerned that the pressing need in this most important area of health care is being treated with cavalier indifference. Of 200,000 thousand people working for the Veterans' Administration, there is in the neighborhood of 150 people who are employed in the geriatric program. It is evident that the program is not receiving the attention it deserves, just as it is patently clear that not enough research has been done on the hospice program for the care of terminally ill patients. It would appear that these urgent priorities have been relegated to the bottom of the list for the purpose of allocation of resources.

In the same vein, the VA has projected a construction program of nine nursing home care centers in 1982 with an additional 22 homes in fiscal years 1983 through 1986. The need for these facilities is evident, particularly when it is realized that approximately 45 percent of all the veterans cared for in VA medical centers are more that 55 years of age. And yet, this modest construction plan set by the Veterans' Administration will not achieve reality by reason of fiscal and other restraints.

This, Mr. Chairman, concludes my statement. Thank you.

[The prepared statement of Gabriel P. Brinsky, director, national legislative service, AMVETS, and AMVETS' response to written questions submitted by Hon. Alan K. Simpson, chairman of the Senate Committee on Veterans' Affairs, follow:]

PREPARED STATEMENT OF GABRIEL P. BRINSKY, NATIONAL SERVICE AND LEGISLATIVE DIRECTOR, AMVETS

AMVETS appreciates the courtesy and the privilege extended by this Committee to express its views. We will attempt to address ourselves to the concerns identified by the Chairman of this Committee in his letter of May 28. In all frankness, however, we feel that the Veterans Administration is better equipped to respond to some of the queries which have been raised. Nonetheless, we will to the best of our ability attempt to evaluate the problems and identify the matters in the aggregate which were identified as of particular concern to the Committee.

Because of the time restraints imposed, we will briefly highlight our anxieties concerning what we perceive to be forces influencing the Veterans Administration health care system as we know it today. We request that our complete statement be incorporated into the record.

Allow me to begin by stating that less than 10 years from now, 2 out of every 3 males in the United States over the age of 65 will be a veteran. It is projected that in less than 20 years there will be more than 8 million veterans when almost one-third of the veteran population will be over 65 years of age. This is worth pondering a moment as to what it translates into in terms of need for health care facilities and resources. In this framework of patient potential we must also accept the fact that older patients require frequent hospital admissions with its longer hospital stays and, of course, more medical attention by physicians. It is common knowledge that the older veteran is more likely to develop more complicated illnesses. It is reported that they see physicians 50 percent more often and that their illnesses last almost twice as long than in the younger population. It is obvious, therefore, that more health care resources are needed if the demands of the aging veteran are to be met. Yet we are being faced with attempts to erode the VA health care system. This will be dealt

with in greater detail in the statement which is being submitted for the record. Orally, we wish to concentrate upon what we, in AMVETS, consider vital and that is the state of geriatrics as it relates to the needs of the elderly veteran population.

Currently there are eight VA geriatric research, education and clinical center programs, referred to as GRECC. The program was initially established in 1973. Public Law 97-330 authorized the development of seven additional geriatric centers. One of these was planned for Camden, New Jersey, which was scrapped. We are extremely concerned that the pressing need in this most important area of health care is being treated with cavalier indifference. Of 200 thousand people working for the Veterans Administration, there is in the neighborhood of 150 people who are employed in the geriatric program. It is evident that the program is not receiving the attention it deserves just as it is patently clear that not enought research has been done on the hospice program for care of the terminally ill patients. It would appear that these urgent priorities have been relegated to the bottom of the list for the purpose of allocation of resources.

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We will now address ourselves to the request by the Committee that we address all aspects of the VA outpatient care and include certain

concerns which were identified. A question posed by the Committee is what methods do VA outpatient clinics use to administer the outpatient eligibility priority system?

Priorities for entitlement to outpatient treatment care is set forth by statute and implemented by regulations and guidelines set forth by the Veterans Administration. It must be assumed that these criteria are being followed and that the facility providing the outpatient treatment insures that priorities are assigned according to law.

Is the VA outpatient system presently equipped to adapt to the unique and rapidly growing needs of the aging veteran population during the next decade?

Because of the anticipated greater demand to be placed upon the system it can be reasonably concluded that the present system is not adequate. However, there is no reason to believe that the present system cannot be adapted to take care of the greater influx of those seeking medical attention.

Should it be adapted to meet the needs that this largely nonservice-connected population will have?

The answer to this question will depend primarily upon the philosophical interpretation which is placed upon the veterans health care program. In the opinion of AMVETS, it should be adpated to meet the needs of the largely nonserive-connected veteran population. We are of the firm conviction that the VA Medical Health Care Program System was established by Congress for the purpose of taking care of those who served. Since the World War Veterans Act of 1924 was enacted, Congress began to provide in

more positive terms for the war veteran and following World War II the present VA system, as we know it, really came into existence. The Congress wanted to provide those who served with their own health care system. And this is completely understandable and justifiable. It was just another way to acknowledge the contributions which have been made by those who have served.

But an unexpected windfall occurred. The VA health care system with its university affiliations and its fast resources provided benefits which accrued not only to veterans but to the population as a whole through its research and other efforts. Where inpatient or outpatient facilities to be limited to the service-connected veteran, it is universally accepted that the system as it has developed and will continue to grow could not do so without the inclusion of nonservice-connected veterans within its parameters. It is the very essence of vastness and variance which brings to the system the necessary medical feedback which is vital to the development of meaningful research and treatment. Without the inclusion of nonservice-connected veterans in the program, the VA health care system is destined to fade away. If we are to maintain the present efficient, cost-effective VA health care system we will need the nonservice-connected veteran population to do so.

In what capacity does the VA outpatient system provide primary, chronic, and acute health care?

A partial response to this question is made in the preceding paragraph. Basically, the VA outpatient system provides the services through a mandate of Congress as the designated provider for those who have served this nation.

Is the VA outpatient resource allocation method effective throughout the system? Does it give consideration to the changing geographic and demographic situation in the "Sun Belt" regions?

As to the effectiveness of the outpatient research allocation, the Veteran Administration is better equipped to furnish the particular statistics which might have a relevancy. Obviously, changing geographic and demographic considerations pose a problem which must be met on a continuing basis of evaluation. It is certain that the Veterans Administration is extremely cognizant of the problems created by the shift in populations. and particularly as it exists in the sun belt regions.

A concluding concern expressed by the Committee is that of the growing number of eligible women veterans in VA outpatient health care system and the appropriateness of continuing to provide over-the-counter medicine and beneficiary travel benefits to nonservice-connected veterans.

Our respondents in the field have indicated that occasional problems arise in obtaining admission for our female veterans into nursing homes or to specific hospital facilities because of the lack of provisions made for the care of these individuals. We believe that this is a matter which must be addressed by the Veterans Administration but we do not view it as posing any substantive problem or obstacle to the furnishing of the necessary health care to the female veteran population.

As regards the matter of providing over-the-counter medicine and beneficiary travel to nonservice-connected veterans, we regard it as a matter as to how generous a grateful nation wants to be. As we view it, by no standard is it a vested right. Nor do we see it as an inherent right arising out of service.

Before concluding our testimony, there are certain observations that we would like to make. Prior to the enactment of Public Law 96-22 the location of VA medical facilities was determined by the Administrator of Veterans Affairs subject to the approval of the President. Under the current law, both the Senate and the House Veterans Affairs Committees' approval are required for construction projects costing more than $2 million or annual leases exceeding $500 thousand. The construction projects have been justified by the Veterans Administration and have been approved. Yet, their construction have been delayed while a study project is being undertaken. The expanded geriatric research and care program authorized by Public Law 96-330 was not funded in 1982 and again in 1983. While the Hefner Amendment which restored $250 million in outlays in the budget authority for the Department of Medicine and Surgery of the Veterans Administration Program, will alleviate the pressures placed upon the health care program, it is obvious that it is far from sufficient.

We strongly urge that the Veterans Administration in implementing the requirements of the law as set forth in Public Law 96-330 fully recognize that the pioneering efforts in the area of geriatrics must be undertaken which would extend beyond that which might be obtainable through the structure experience of present Veterans Administration establishment. While we strongly commend the activities as outlined by Dr. William Jacoby of the Department of Medicine and Surgery of the Veterans Administration before the Veterans Committees, we believe that consideration should be given to seeking research outside of the confines of medical discipline. We are of the opinion that the creativeness and the imagination which must be brought to this important area is beyond the limits of the medicinal science. We urge that scientific research be addressed to areas of the

psycho-socio problems with which the aged veteran might be faced and the environment in which he can be best treated.

In conclusion, AMVETS is of the opinion that the treatment and care of the nonservice-connected veteran is vital to an efficient and productive Veterans Administration Health Care System. We are of the further conviction that it is the desire of the Congress of the United States that health care through a system provided particularly for them be accorded to the veterans who have served this nation. We are also of the view that the future will bring us face-to-face with the question of geriatrics which will be unique as a problem which we are to face. In this respect, we believe that the Veterans Administration has not been complying what the mandate of Congress set forth in Public Law 96-330. The Veterans Administration with its resources and capabilities should be a pioneer in this field of geriatrics not only for the veterans which it serves but also for the benefit of the entire civilian population. It has the opportunity, as it has had in the past, to pioneer and lead the way in an area which is vital to the health of this nation.

This concludes my testimony, thank you.

RESPONSE OF AMVETS TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN K. SIMPSON, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1.

Do you believe that VA outpatient eligibility standards are are being fairly and uniformly applied throughout the VA health-care system?

Do you believe these standards are inappropriate? If so, how would you change them?

Answer 1.

Within our knowledge, the VA outpatient eligibility standards are not being uniformly applied throughout the VA. We do not believe that this is intentional or is done by design. Rather, it is brought about by the varying situations regarding total veteran population served in certain areas and the amount of resources available within that particular area. For example, eyeglasses are furnished by two pairs in certain medical jurisdictions while only one pair is provided in others by reason of limited resources. Where the demand is heaviest for glasses, obviously the resources which are available for that purpose are stretched thinner than where an area is serviced by a medical facility where the requests are proportionately much less. Thus, where such lack of uniformity applies in the application of eligibility standards, it is dictated by what is available rather than by any arbitrary application of regulations or instructions.

In response to the second part of the question, in our opinion the standards which are being applied are, within reasonable limits, appropriate to the circumstances prevailing.

Question 2.

How would you rate the quality of care being provided in the VA outpatient health-care system?

Answer 2.

In our opinion the quality of care being provided by the Veterans Administration equals or exceeds that which is available in the private health care sector. This is not to suggest that there is no room for improvement. There is a problem in terms of waiting time just as there is in non-VA facilities. The quality of the care extended is as good as can be found anywhere. While the question has not been posed, we would like to observe that it is more cost-effective than what is otherwise available.

Question 3.

How effective is the initial health screening process that is conducted for nonservice-connected veterans before outpatient health-care treatment is administered?

Answer 3.

If by "effective" is meant how uniformly is the screening process administered before outpatient treatment is accorded to nonservice-connected veterans, it would be our observation that there are some variations in its application. The requirements as spelled out under the controlling laws and regulations are very familiar to the Committee and therefore will not be stated. But the criteria which is employed is not reduced to specific measures which can be uniformly without room for deviation be applied. This is to say, that there is flexibility in interpretation and how it is interpreted depends upon the individual who is making the judgment decision. For in many instances, it is a judgment call and a medical opinion. Therefore, even though an attempt is made to uniformly apply the criteria and to have a uniformity of screening procedures, the human element makes this a difficult goal to obtain.

Question 4.

Do you believe that referrals of non-service veterans by the VA to community health services are generally appropriate, effective, and standard throughout the country?

Answer 4.

To reply to this question, the AMVETS' position must be stated which is that we are categorically and vehemently opposed to any referral of nonservice-connected veterans to community health services. It follows therefore that we are of the impression that the community health services are not appropriate, and are not effective.

It is our belief that the VA health-care system, outpatient treatment, is the most cost effective and is most responsive to the particular type of clientele that it treats. The VA health-care system is atuned to its clientele. The patients, in turn, respond to the empathy. There is no such a relationship where the services are provided by the community. And most important, the cost effective feature must be considered. There is no question that the VA health care-system is much more efficient, economically and otherwise, than any community health care facility.

Question 5.

Do you have suggestions concerning the VA's practice of scheduling multiple clinic visits on separate days instead of on a single day in many cases?

Answer 5.

The obvious answer is to schedule the various clinic visits for the same day where practicable. Unfortunately, many physicians who practice specialties are available only on certain and limited number of days. The problem arises where there are multiple clinic visits to be conducted and the schedules of the attending physicians in the various specialties do not coincide. At best, attempts can be made to schedule specialists with the same work day schedule for clinic visits at that time.

We recognize that this is a problem but it is not unique to the VA system. The same is true in the private sector when visits must be scheduled to accommodate the physicians involved.

Question 6.

What is the impact of medical school affiliations on the VA outpatient health-care system?

Answer 6.

It is the view of AMVETS that the medical school affiliations have had a tremendous impact upon the cost-effectiveness and the quality of the VA outpatient health-care system. While the question addresses itself only to the outpatient care, it is difficult to divorce the effects of the relationship both from the viewpoint of inpatient and outpatient care. But by the research which has been conducted made possible by this relationship, the Veterans Administration has profited. The knowledge gained has become readily available and has been utilized in the effective treatment of outpatient veterans. While certain problems have arisen by reason of the relationship and some criticisms have been levied at the deans' committees, none have seriously contended that this relationship has been anything but advantangeous to the VA health-Care program.

It is our sincere belief that without the medical school affiliations the Veterans Administration would not have the efficient medical care system which it possesses today.

Chairman SIMPSON. You have always been helpful to us in our work on the Veterans' Affairs Committee. And though I don't intend to challenge or be argumentative with some comments, it sometimes does stir in my breast lightly.

And I think that in the course of hearing you out, which I always want to do, the same figures as Don Schwab presents can be used to make the argument the other way. That's the way it is around this place. Everybody just uses their own set of figures and leaves it for Congress to scratch their heads in the process. And it's a great game but it doesn't get the job done.

But I think that it is important that when you speak of a general population increase in 10 years of some 20 percent and the size of the Federal budget and the increases within the increments of the budget, that we might remember that the veterans' population has only increased in that 10 years about 7.1 percent. And I think that is important to keep in mind. And somewhere we always lose track of the fact—and I know it comes on floor debate and every other juncture—that veterans are also citizens of the United States and they draw all of the benefits that citizens draw. And some of them on disability draw social security disability which is a tax free increment.

It's funny how those things get lost in the shuffle. And they should receive those things, that's what I'm saying, but it just is always forgotten in the general discussion. And I can assure you that we have not singled out the veterans as the budget busters of the Nation as quoted there several times. Everything is the budget buster of the Nation. There isn't one thing that we are dealing with that isn't the budget buster.

And as we slog along in this area with this budget it is interesting to note that when we are finished or if the Senate budget proposal was upheld it would still be 36 percent above the 1980 budget. How curious. I think we have all been portrayed now as pinched, and shriven, and evil, and mean spirited, and something out of Charles Dickens, and all we have been doing is cutting the increases proposed by President Carter and cutting the increases proposed by President Reagan, nothing more.

But so it goes. And I have kept up the house payments on my home in Cody and all is in readiness for a return there, perhaps even earlier than I had ever anticipated.

Well, now, I do have some questions. The eligibility for outpatient care for non-service-connected veterans is generally limited to pre- and posthospital care and care necessary to "obviate the need" for hospital care.

Do most veterans in your view, especially those non-service-connected veterans over 65, really understand the various areas of eligibility, the standards of eligibility for outpatient health care? And that such care is only to be provided in VA facilities within existing resources? What is your view of the average veteran's perception of these various discussions and priorities and eligibilities?

Mr. SCHWAB. Mr. Chairman, I think, I believe those who use the facilities, those who are on pension, below the poverty level, live in close proximity, they know the rules of the game. But the veterans who goes there for the first time notwithstanding the efforts of the VA and the veterans organizations to apprise veterans of their eli-

gibility, and has been pointed out in previous testimony, they really don't know. They know they are veterans. They should be able to get health care, they believe, and they go to the VA and then they find the rules.

Chairman SIMPSON. Gabe. Oh, John.

Mr. SOMMER. Mr. Chairman, the Legion, just as I am sure the other veterans organizations do, attempts through our service officers to reach as many veterans as possible and let them know what the eligibility criteria is. However, we don't reach all the veterans. And many times, as Don said, particularly people that do not come to the VA medical facilities frequently, certainly don't understand the schedule of priorities for treatment.

Mr. BRINSKY. My opinion, Mr. Chairman, from what I have noted, most veterans do not understand the requirements. And this, I think, is understandable because there are people who are better versed in veterans matters who do not understand them. Many people don't know the difference between a service-connected and non-service-connected disability. And what veteran can decide whether or not his condition is such that it would preclude hospitalization if he received treatment on the outpatient basis.

I think another thing that leads to the confusion, this very criteria which was set up in 1973 was variously interpreted in the VA facilities. As a result, there were certain facilities providing care to almost any veteran who applied, on the theory provided by the statute which allowed for such interpretation, that outpatient treatment would preclude hospitalization.

So the veterans who at one time were received with open arms suddenly find themselves being refused. And this is kind of difficult to explain to them.

Chairman SIMPSON. Yes, I could see that.

What are your thoughts on the fee basis outpatient care program which certainly has a significant financial aspect on the health-care system. Do you think that fee-basis care should be limited in instances and that those then resources should be used to supplement an inhouse patient program? What are your thoughts? Just briefly each of you on that. If you have any.

Mr. BRINSKY. Well, I believe our position is that the Veterans' Administration from what we can determine have been pretty zealous in their prerogative in granting or authorizing fee basis. I think where it isn't absolutely necessary in their point of view it won't be authorized. And I don't believe that we can deny the fact that fee basis does serve a very useful purpose in outlying areas where there aren't any VA facilities readily available.

Chairman SIMPSON. Do you have any comment, John?

Mr. SOMMER. Yes, Mr. Chairman, our experience has been that in many instances the providing of fee-basis care has been pretty stringently regulated. And as was pointed out earlier in the Veterans' Administration's testimony, there are instances where veterans are too ill to travel any great distance. And in cases like that we feel that the fee-basis treatment certainly is in order.

Chairman SIMPSON. Don, do you have any comments that you wish to make on that?

Mr. SCHWAB. It would only be reiteration and the fact that it must be stringently reviewed by the VA. But it is very necessary.

Chairman SIMPSON. Do you think that the outpatient eligibility standards are being fairly and uniformly applied throughout the VA health-care system, realizing the scattering of the jurisdictions? Generally, do you feel that is being uniformly applied? That those standards are appropriate?

Mr. SCHWAB. Well, our field representatives and service officers believe that the individual VA facilities are administering their priority system to the best of their ability. Service-connected folders are placed in one basket and receive first attention, nonservice connected in another basket. Now here the priority system may breakdown due to no fault of the clinic. If a priority 4 veteran wants to go to E&T and the load is light there he may well be seen before a priority 3 veteran who wants to go to internal medicine where there is a heavy load.

But the clinics are trying their best to cope with the priority system.

Chairman SIMPSON. OK.

Mr. SOMMER. Mr. Chairman, I might just add to that by saying in many cases it is very difficult, particularly in your large metropolitan areas where the clinics are overcrowded most of the time. I'm sure that the Veterans' Administration is dealing with this—eligibility clerks and people who are handling the veterans as they come in—to the best of their ability. However, I'm sure that it is difficult.

Chairman SIMPSON. Well, just one more question. What are your views on the two or three alternative programs that were discussed today at various times to supplement outpatient care: The Dr. Charles group practice model and the traveling clinic method, both experiments discussed. What are your views on those, please?

Mr. SOMMER. Mr. Chairman, we are not familiar with these treatment modes, however, they do sound quite interesting and we will certainly look into them.

Chairman SIMPSON. Please. I'd appreciate if you would have your field people take a look at them and judge them for us. Give us your comments.

Mr. BRINSKY. Mr. Chairman, I believe that nothing but advantage can result from this type of experiment or study, if you will. Certainly what we are doing now in terms of outpatient care treatment or inpatient for that matter, always warrants another look and I think continuous reviews in searching for new methods of accomplishing the end purpose is always desirable.

Chairman SIMPSON. Thank you. Any comment, Don?

Mr. SCHWAB. Sir, if they can furnish the needed care on a cost-effective basis, I think it is highly commendable.

Chairman SIMPSON. Well, I think that they indicate they are going to pursue those things. And if your people and your field people could give us your views of it that will be helpful.

We have statements for the record from Dr. Richard M. Ryan, Jr., representative of the Special Medical Advisory Group and Dr. Thomas Inui, from the VA Medical Center in Seattle. And without objection those will be submitted in the hearing record.

[The prepared statement of Dr. Richard M. Ryan, Jr., associate dean of the Harvard Medical School and member of the Special Medical Advisory Committee of the U.S. Veterans' Administration,

and Dr. Thomas S. Inui, chief, Medical Comprehensive Care Unit and director, Health Services Research and Development Program, Veterans' Administration Medical Center, Seattle, Wash., associate professor of Medicine and Health Services, and codirector, Clinical Scholars Program, University of Washington, follow:]

PREPARED STATEMENT OF DR. RICHARD M. RYAN, JR., ASSOCIATE DEAN OF THE HARVARD MEDICAL SCHOOL AND MEMBER OF THE SPECIAL MEDICAL ADVISORY COMMITTEE OF THE U.S. VETERANS' ADMINISTRATION

Mr. Chairman and Members of the Committee:

Although I was unable to appear before your committee in person, I thank you for the opportunity to comment on the important issue of eligibility for veterans to receive medical care in the VA Health Care System.

As the U.S. Veterans representative on SMAG, I was privileged to work with the staff of the Department of Medicine and Surgery (DM&S) in preparing the eligibility study directed by Mr. Calvin Chandler and DM&S staff and discussed by Dr. Richard Schmidt, Chairman of SMAG, in his 1981 report to this Committee.

I do not intend to reiterate what has already been reported upon. However, I will focus on what I perceive to be major issues confronting the VA relative to eligibility and entitlement.

The social-demographic characteristics of the veteran population suggest that a high demand for services related to the aging veteran population will impact on the VA over the next twenty years and on into the 21st Century.

The dual entitlement status of the over sixty-five veteran population makes it extremely difficult to plan for geriatric services. Will all vets 65 and over be entitled to comprehensive care in the system? Should this be

a major priority of the VA? If so, what about the spouse of the aging veteran? Does it make sense for spouses to receive geriatric care isolated or fragmented in nature? In addition to the question of whether the VA can meet current entitlement obligations is the question of whether it has the capacity to change quickly enough to provide an adequate geriatric base and to simultaneously provide the resources necessary to meet its other obligations.

Recent legislation pertaining to Viet Nam veterans priority in assessing care has created a de facto "competition" between veterans of different wars for limited resources. Those older veterans who previously were first in the priority system are now relegated to lower priorities or excluded from certain kinds of care. The results are well known to you. Care is rationed. Demand is controlled. Needs are not met within the system.

Why, then, is there not an outcry about the veterans eligibility nightmare? The answer may be found, I believe, in the fact that the funding base of the VA as a percentage of the total federal budget has actually decreased. The Department of Medicine and Surgery budget has been functionally decremental for the past five years. However, some veterans have their health care needs met adequately within the system, some have more limited success and some meet with rejection.

The process of determination of eligibility is often idiosyncratic and appears to vary from facility to facility within the system. Despite all this, the system works, provides overall quality care at reasonable prices and is meaningful to its constituents. Understandably the attitude among many veterans' advocates is: "Why ask for trouble?"

One answer might be that a crisis is building on several fronts. Repeated years of decremental budgeting have resulted in the overall reduction of 35,000 hospital beds since 1965 and an impressive 18,000 bed decrease since 1970. That, Mr. Chairman, is equivalent to closing 36 five hundred bed hospitals.

The workload of the VA outpatients tripled during the same period and the inpatient treated doubled. Each year 400,000 additional elderly veterans and untold others are eligible for care in the system, yet the budget increases do not keep abreast of inflation.

At what point does the system become marginal?

The question of which veterans are entitled to care, who is to be eligible, how many can be treated and what judgements are required to maintain a high quality program for veterans requires a careful study by the Congress and the Administration and the total support of veterans groups and the VA.

I believe that we cannot afford to avoid the unavoidable and must examine this set of issues in the full social and political light of the times. To continue to say that this system will provide for all and then to practice discrimination in providing care is hypocrisy.

Thank you for permitting me to comment.

PREPARED STATEMENT OF DR. THOMAS S. INUI, CHIEF, MEDICAL COMPREHENSIVE CARE UNIT AND DIRECTOR, HEALTH SERVICES RESEARCH AND DEVELOPMENT PROGRAM, VETERANS' ADMINISTRATION MEDICAL CENTER, SEATTLE, WASH.; ASSOCIATE PROFESSOR OF MEDICINE AND HEALTH SERVICES, AND CO-DIRECTOR, CLINICAL SCHOLARS PROGRAM, UNIVERSITY OF WASHINGTON

Herein, I will try to outline briefly some of the problems and issues which seem to me to be particularly relevant to VA ambulatory care. I have divided my thoughts into three sections: problems and issues from the perspective of the patient, the physician, and the VA system. These certainly are not listed in order of importance, but simply as they occurred to me.

The Patient.

Eligibility. The VA system of eligibility categories is byzantine and virtually unknown to physicians and patients. The objectives of this "prioritization" system in ambulatory care is unclear. In 1976, when I first came to the Veterans Administration, the only functionally important distinction was between service connected and non-service connected veterans. Even that distinction was of little immediate relevance, since we had "room for" both categories of veterans in our ambulatory care patient panels. Since that time, we have had to be progressively stringent in our exclusion of non-service connected veterans from certain sectors of our ambulatory care facility, resulting in "crazy quilt," patchwork accessibility to some but not all ambulatory care clinics at this hospital. Patients, by way of contrast, believe that they are fully "eligible" if they have served in the military. They have little understanding of and sympathy for even the service connected/non-service connected distinction. Under current circumstances, in certain situations, service connected veterans are competing with one another for scarce ambulatory care resources at this hospital (for example, my clinic, the Medical Comprehensive

Care Unit). In spite of the existence of various categories of service connected veterans, there seems to be very little potential for further operational "discrimination" among service connected veterans applying for care.

Episodic vs. Continuous Care. Once a veteran has "enrolled" in our ambulatory care clinics, he is apt to assume that he may remain in those clinics until such time as he withdraws or has been "cured." Most of our patients are seen, of course, for chronic conditions, precluding the possibility of "cure." We, like other VA hospitals, have had to begin to discharge patients from ambulatory care clinics (especially "old" non-service connected patients who enrolled in these clinics several years ago when there was no scarcity of clinic slots). This means we are returning to an emphasis on episodic (especially post-hospital) care, and violating informal "contracts" we made with patients for continuous care. This is an unanticipated and disconcerting experience for our patients, and a discouraging one for the physicians.

Expectations vs. Realities. Both the eligibility situation and our increasing emphasis on post-hospital care for low-priority patients clearly falls short of patients' expectations. Every Friday afternoon when I work in our Problem Evaluation Clinic (the walk-in clinic at this hospital in which patients apply for care), I oversee nurse practitioners who spend a good deal of their time explaining to veterans why we are unable to offer them services they seek. Even if they have a condition which permits us to refer them to one of our "open" clinics, they may or may not be able to gain access to other clinics of the hospital in which they should receive care for one or more of their (usually multiple) problems. This incomplete response to their needs by our local system represents administratively responsible management, but a good deal of the time creates an adversarial atmosphere between providers and patients, hardly conducive to the healing function. Our referrals to "low cost" alternative sites for care in the greater Seattle community do not really solve this problem. Many of our patients in the current general economic situation come to us as an option of last resort because they truly cannot afford to underwrite the costs of their medical care in any other setting.

The Physician.

Academic vs. Clinic Responsibilities. This must be a classic problem for staff in fully affiliated hospitals. All of us came to this VA hospital with a clear understanding of our time commitment to patient care. I have honored that "contract" but at the cost of a considerable work burden on evenings and weekends. It is not really the formal teaching activities (clinical and non-clinical) which cause me most distress. Hospital committees, research administration, and academic departmental governance committees occupy a very considerable fraction of my time and energy, clearly reducing my clinical productivity.

Working in a "Mixed" Health Care and Welfare System. Because the Veterans Administration has both a compensation/pension system and a medical care system (in parallel) I often find myself asked by my patients to provide supporting evidence for their claims of disability. There actually is a fairly clear distinction between medical care and examinations for disability in our system, but this distinction is not appreciated by our patients. The "secondary gain" problem looms large in VA medical care and has a detrimental effect on physician-patient relationships.

Cost-Effective Practice. There actually are penalties for patterns of practice which are cost-effective in the VA. The best example of this may be our attempts to coordinate appointments for our older patients or those who come from a considerable distance. Since the VA considers (and within assigned workloads recompenses our hospital for) only a single appointment for a visit to the hospital on any given day, if a patient of mine comes to this hospital for multiple appointments on the same day (e.g., medical clinic and urology), this is counted as "one" visit. From the perspective of our hospital's revenues and clinical budget, therefore, it is better to schedule such a patient for separate appointments to the medical and urology clinics on different days rather than to coordinate these appointments. This clearly makes little clinical sense, but is sensible from an administrative perspective. A similar argument can be made for frequent visits vis-a-vis pharmacy costs. Drug resources for the chronically ill person taking medicines on a regular schedule are a "fixed cost." If a patient has two visits in a 6-month interval, instead of one, the hospital is reimbursed for "visit costs" twice (defraying pharmacy costs). Whatever the actual medical appropriateness of two visits versus one might be, the incentive for shorter between-visit intervals is clear.

The VA System.

Changing Population. We all know that the VA population is aging, and that the problems and medical care needs of this population are changing as they age. Additionally, the general economic depression in this region is increasingly forcing VA eligible persons, who had previously been employed or using Medicare, to apply to this hospital for health services. Our "user population," therefore, is changing rapidly, in my perspective becoming older, sicker, and poorer apace.

Planning. These changes in the population we serve obviously make it difficult to plan from one year to the next. To further compound this problem, we are "assigned" our ambulatory care allowable workloads. Where these assignments come from and how they are determined, I do not know. The workload estimates seem to me to be a reflection

of budget planning, instead of vice versa. It could be argued, you see, that workload estimates ought to determine budgets. In a system in which our working capital and planned expenditures result from a political negotiation process, it is very difficult to take any rational approach to planning.

Bed Orientation. At first blush, this must seem an odd category for a discussion of ambulatory care problems. What I have in mind here, however, is the VA's approach to staff sizing and allocation. As far as I am aware, a given VA medical center has staff size set by application of (one of several alternative) staff-to-bed-day ratios. Effectively, this means that the size of the total hospital staff is dependent upon the size and level of activity of that hospital's inpatient service. Under these circumstances, any hospital director who decides to expand his/her medical service by creating a staff of physicians who will work in the ambulatory care clinics, does so at the expense of "attending physician manpower" on the inpatient services. The emphasis on inpatient-based staffing ratios, then, makes it difficult for our hospitals to create ambulatory care staffs. To further compound this problem, at our hospital the creation of the ambulatory-care general internal medicine staff in the Medical Comprehensive Care Unit (general medicine clinic) has coincided with a general decline in medical service bed occupancy. While we have no way of demonstrating this putative cause-and-effect relationship, it appears that better outpatient medical care has reduced the number of needed inpatient episodes. Once again, in the long run this will make it more difficult for our hospital director to support his general medicine section, since our presence and our work will ultimately result in a lower allowable medicine service FTE ceiling.

Productivity and Quality of Care. Above, I have alluded to a conflict of academic and clinical responsibilities for the staff at affiliated VA hospitals. From a management perspective, this problem looms even larger. If an academic staff member is giving 50% of his/her time for academic teaching and research, a full time salary must be paid for a (net) half-time clinical physician's services. Furthermore, if the 50% time committed to clinical services is subject to attrition or inefficiency because of academic or administrative responsibilities, the cost-effectiveness of an academician from a clinical management perspective is even more reduced. Clearly, the alternative is to hire fulltime clinicians who have no academic responsibilities. The prevailing impression is that these clinicians will be of "lower quality," putting the patients at risk for "lower quality of care" and diminishing the reputation of the institution generally. This is a conventional wisdom in the VA, but I am uncertain whether it is altogether valid. In an institution like Seattle's, it might be possible to attract a clinical staff who don't wish to do research and publish, for example. If current physician manpower estimates are correct, we are faced with a surplus of physicians in the intermediate term. Under these circumstances, there may be a larger pool of physicians from which to hire and creation of good-quality clinical staff groups at VA institutions may not be so difficult to achieve.

Chairman SIMPSON. There will be other questions to be submitted by Senator Cranston and perhaps other members of the committee. I thank you very much for your usual good cooperation and assistance and your help as we pursue veterans' issues in this Congress. Thank you very much.

And that concludes the hearing.

[Whereupon, at 11:40 a.m., the hearing was concluded.]

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